

**PERSPECTIVES ON OCCUPATIONAL
THERAPY TRANSFORMATION IN
SOUTH AFRICA**

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Minor Dissertation Submitted In Partial

Fulfilment of the M.Sc. O.T. Degree

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**Perspectives On Occupational Therapy
Transformation In South Africa**

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A Minor Dissertation presented in partial fulfilment of the degree Master of
Science in Occupational Therapy at the University of Cape Town

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(Romans 8:29)

Declaration

I, EM DUNCAN hereby declare that the work on which this minor dissertation is based is my original work (except where acknowledgements indicate otherwise), and that neither the whole work, nor any part of it has been, is being, or is to be submitted for another degree in this or any other university.

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Date

Abstract

This minor dissertation is built around the Vona du Toit Memorial lecture that was given, by the author, to the Occupational Therapy Association of South Africa (OTASA) in July 1999. The central theme of both the lecture and the dissertation is professional transformation, the impetus for which is seen to reside in the axiology of the profession, starting with the moral values, attitudes and beliefs of individual practitioners and moving towards a collectively revised professional ontology. It is proposed that the identification, analysis and resuscitation of the profession's ethos at an individual level will ultimately impact transformatively on the nature and characteristics of the profession collectively. Particular emphasis is placed on undergraduate ethics curriculum reform for the vision of transformation at an individual level to be realised.

The dissertation documents the pilot phase of a dialectical research cycle (Reason 1981) during which the author developed perspectives about the ethical concerns that the occupational therapy profession in South Africa needs to consider in the light of its past during apartheid and in view of its future in a developing nation.

It contains a conceptual analysis of the pivotal role that professional ethics and morality will have to play in effecting fundamental change in the philosophical, structural, political and educational dimensions of the profession in response to the unique demands of the African context and suggests practical educational strategies through which attitudinal transformation in undergraduate occupational therapy students may be achieved.

Description of Concepts

1. **Occupational Therapy**

Occupational therapy may be described as the health discipline concerned with enabling competence in human occupations, that is the tasks and activities of everyday life which may be disrupted due to illness, injury, developmental delay or environmental influences. It is guided by the occupational therapist's understanding of the individual, the environment and their interaction in determining occupational competence and well being. (Palatajko, 1992) Practice is concerned with a client's strengths and capacities and situational problems, and with the need for interactants - the client/s and practitioner - to generate personally relevant solutions to the challenges and problems of living.

What an occupational therapist does, evolves in the context of the intervention and is not predetermined. (Creek, 1998) Occupational therapy is therefore a personal, pragmatic service, contiguous with the client's lifeworld contexts. It focuses on real life situations and needs at a point in time, and uses purposefully undertaken occupations as a means of adaptation to life's challenges. The role, scope and methods of occupational therapy appear to be different in different contexts and across age groups and problems. (Jenkins, 1998) Clients may be individuals or groups

2. **Morality**

"Morality refers to the value dimension of human behaviour and decision-making. the language of morality includes adjectives such as 'good' and 'bad' (or evil); 'right' and 'wrong'; 'just' and 'unjust' to describe human beings, their behaviour and their decisions." (Roy, Williams and Dickens, 1998)

3. **Ethics**

"Ethics is the study of morality. It is the careful and systematic reflection of moral decisions and behaviour whether past, present or future." (Roy, Williams and Dickens, 1998)

4. **Ethical Concern/Ethical Issue/Ethical Dilemma**

"An issue (concern/dilemma) involves conflict and controversy. Ethical issues bear upon the rights and wrongs of human decision-making and behaviour. They involve conflicting beliefs about how human beings should live, about the values individuals and groups should uphold and about the values that may be sacrificed when all values in a situation cannot be honoured and maintained." (Roy, Williams and Dickens, 1998)

5. **Moral Sensitivity**

"Moral sensitivity is the awareness of how our actions affect other people. It involves being aware of the different lines of action and how each line of action could affect the parties concerned. It involves imaginatively constructing possible scenarios and knowing cause-

consequence chains of events in the real world; it involves empathy and role-taking skills.”
(Rest and Narvaez, 1996: 23)

6. **Human Rights**

“A human right is something everyone has simply because they are human beings. A right is seen as being good for a person or group of people. The dictionary says a right is ‘that which is morally or socially correct or just; fair treatment: justification or fair claim; a thing one may legally or morally claim” (Health Rights Charter, National Progressive Primary Health Care Network, 1995)

7. **Social View of Health**

Physical, social, emotional, economic, cultural and environmental factors are key determinants of individual and social health. Social justice is therefore required to achieve health outcomes across society. (Westhorp, 1995)

8. **Social Justice**

requires the redistribution of wealth, power and resources. Access to information and services, participation in decision-making and empowerment are critical strategies towards social justice objectives. (Westhorp, 1995) The foundational features of occupational therapy are consistent with the foundational features of social justice. Correlation is nested in features such as belief in the power of people to act in the world, inclusivity, interdependence and power-sharing for the achievement of common goals. (Townsend, 1993)

9. **Primary Health Care Approach**

is a philosophy of health based on the empowerment and participation of individuals in determining their own health outcomes. Individual and societal health are inextricably linked, therefore work at both levels is required in order to achieve lasting outcomes at either level. (Westhorp, 1995)

10. **Systems Approach**

focuses on the interaction between systems. At the individual level, the focus of interaction is between the individual and his or her context. At a social level, focus on the interaction between individual and societal levels is the point of change. (Westhorp, 1995)

Introduction

This dissertation incorporates the 17th Vona du Toit Memorial Lecture delivered by the author, as integral to the enquiry process dealing with the need for transformation of the occupational therapy profession. The lecture is given gestalt at two levels:

- ◆ At a professional level (as a public address and in published form in the South African Journal of Occupational Therapy), it acts as a potential precipitant among a number of strategies to effect transformation in South African occupational therapy. The lecture presents a broad, albeit sparing, vision of the philosophical, structural, political and educational dimensions of the profession within which transformation is indicated. As part of this dissertation, the memorial lecture captures the author's conceptual analysis of the critical issues at stake in the individual and collective transformation process.
- ◆ At a learner level, the lecture and the dissertation expand the notion of educational transformation, which is the focus of the author's current research into the moral development of undergraduate occupational therapy students.

The dissertation is presented in five sections. The first orientates the reader to its purpose and to the research methodology being followed. The second section is a prologue to the lecture. It charts the author's journey of discovery in identifying a topic for the memorial lecture and subsequently researching, writing and delivering it. Woven into this narrative is an extensive literature review and conceptual analysis of emerging themes that inform the lecture and substantiate the need for undergraduate ethics curriculum reform, and confirm the author's current research. The third section presents the memorial lecture as a public address. A few of the slides used during the lecture have been included. The fourth section is an epilogue that discusses the practical implementation of some of the educational transformation strategies recommended in the lecture. The dissertation concludes with recommendations.

Purpose of Dissertation

The combined purpose of the lecture and minor dissertation is firstly, to share perspectives on the transformation of South African occupational therapy practice and training and secondly, to document the pilot phase of the author's research into the ethical development of undergraduate occupational therapy students.

The Research Methodology

This dissertation, which includes the memorial lecture, documents the author's emerging interest and research into professional transformation in general, and into the ethics education of undergraduate occupational therapy students in particular. To this end, I relied on social research methodology. Peter Reason (1981) presents a cogent argument for human inquiry to be based within a dialectical paradigm that places the research emphasis on process, change and movement. Social research recognises that the way humans change is seldom smooth or continuous but rather fraught with contradictions, conflict and opposition. Dialectical human inquiry seeks to understand the interdependence, interpenetration and unity of opposites. It sees knowledge not as a thing we can 'have' but rather that the process of 'knowing' is personal, circular and contradictory. (Rowan and Reason, 1981: 113-137)

Research within the dialectical paradigm entails a *"number of interlocking cycles which spread a net over the phenomenon we are studying. This gives a new way of seeing pilot work ... instead of wanting to get rid of the pilot work as soon as possible and get on with the 'real thing', we start being very interested in different kinds of pilot work and how they can throw light on one another. We start to call them early cycles instead of pilot work and learn from them as much as possible."* (*Ibid: p 105*) Similarly, the cycle of researching, writing and delivering the lecture and placing it at the centre of a similar process in this dissertation; acts as two components of the pilot phase in the author's current research mentioned above.

Peter Reason (1981) proposes a generic cycle model of research that, he believes, is as applicable to basic, objective research as it is to participatory, dialectical research. The research process can commence at any one of six moments in the cycle because different people need to start at different points and different research methods require different combinations of these six points.

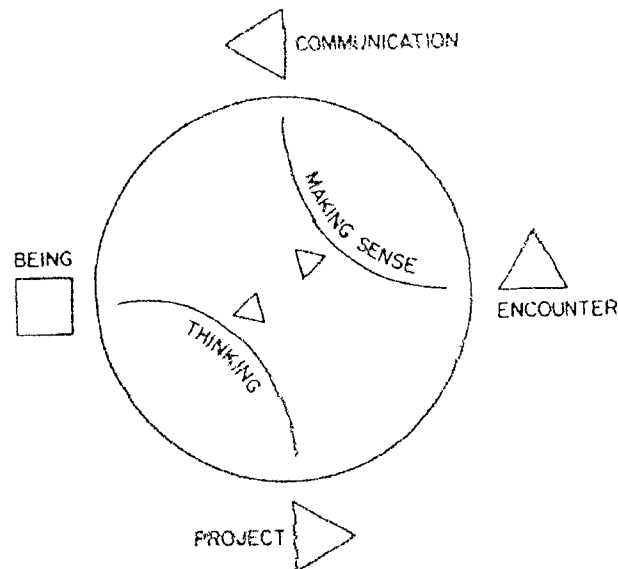


Figure 1 - The Cycle Model (Reason, 1981: 98)

A summary of the dialectical process at each of the six moments in the Cycle Model (fig 1): (Reason, 1981) follows:



BEING

- ◆ Resting in my own experience
- ◆ At a certain point, my existing practice seems *inadequate*
- ◆ I become dissatisfied – a problem is evident
(dialectic: turning against old way of doing things)



THINKING

- ◆ Start *new thinking*; *find out what others already know*
- ◆ Inward, processing movement
- ◆ Invention; trying out new ideas; adding new information
(dialectic: not having enough/ having too much information)



PROJECT

- ◆ Thinking is not enough; definite focus emerges
- ◆ Outward, action movement; a product or project emerges
- ◆ Builds a bridge towards that which contradicts the present reality
(dialectic: plans are enough/no plan can be perfect)



ENCOUNTER

- ◆ Meet the other, doing
- ◆ Regular inward and outward movement
- ◆ Involvement, engagement, commitment, spontaneity
(dialectic: *disconfirmation is more valuable for learning than confirmation*)



MAKING SENSE

- ◆ Analysis, contemplation
- ◆ Finding meaning, trying to understand

- ◆ Immersion, turn experience into knowledge
(dialectic: reduce data to understandable simplicity/ expand connections between data)



COMMUNICATION

- ◆ Share understanding, outward explanation
- ◆ New accommodation to reality, resting in a new place; back to 'being'
(dialectic: get data more clearly expressed/impossible to communicate with anyone outside the experience)

At each of these moments six main types of questions need to be asked (that is, multiple cycles start occurring) in order to confirm the process. (Appendix 1 reflects how I have used these questions to explore the BEING and THINKING moments)

These include:

Positivist / efficiency questions: How can validity be tightened up to give maximum hard data?

Alienation / authenticity questions: Which people are involved in the research, and how deep is their personal commitment?

Political / patriarchal questions: Whose interest does the research serve?

Dialectical questions: Which philosophical assumptions exist?

Legitimacy questions: Is a proper research job possible within a given context?

Relevance questions: So what? Are the findings of any real use?

The development of the memorial lecture, the crafting and subsequent implementation of a research protocol to investigate the moral development of undergraduate occupational therapy students and the documentation of this dissertation are experienced by the author within Reason's (Ibid) multiple research cycles. It is extremely difficult to dissect, extricate or pinpoint exactly, the various moments that apply to the events and experiences described in the prologue which follows. A number of moments may occur simultaneously within these enmeshed processes. The most important issue is, however, the successful negotiation of the dialectic and progression through the cycle. As with all qualitative research, rigour resides in the author's ability to demonstrate authenticity and congruence in triangulating his or her conceptual analysis. I believe that the credibility of my current research will be significantly enhanced by the process of researching, writing and delivering the memorial lecture and subsequently, by the documentation of this dissertation. It freezes, as it were, my thinking at points in time and allows me to take stock of what I am learning and trying to make sense of, thereby strengthening the validity and reliability of my research.

I believe that as a novice qualitative researcher:

- ◆ I have gone through this cycle in writing the memorial lecture and this dissertation
- ◆ I am, in my own personal development, going through this cycle
- ◆ Individual occupational therapists and occupational therapy students may process through this cycle if their BEING is sufficiently challenged by the memorial lecture or by the educational strategies suggested in this dissertation.
- ◆ The profession collectively may go through a similar, if not the same, cycle of change and learning. I do in fact suggest in the lecture that it does, and that this constitutes the process of transformation.

Prologue

Introduction

I was invited to deliver the 17th Vona du Toit Memorial Lecture to the Occupational Therapy Association of South Africa in August 1998. The lecture forms part of a series established in 1976 to honour the late Vona du Toit for her leadership in the development of the profession in South Africa. (Appendix 2) Nominees are awarded the lectureship in recognition of their contribution to the profession or to healthcare in general. Deeply honoured by the nomination and acutely conscious of the ensuing responsibility, I set about identifying and shaping a core set of ideas for a lecture that would contribute to reflection and action in the profession; a lecture that would spark debate and introspection in line with Donald Schön's (1983) challenge to professions to examine their purpose and function *in society*. Schön (*ibid*) believes that the debilitating effects of modern practice contexts can be countered by professionals becoming "reflective practitioners" who promote learning from, in, and through, experience.



Entering the BEING Moment (*dialectic: turning against old ways of doing things*)

To arrive at a potentially meaningful lecture, I would have to enter a dialectical research cycle or, as it were, a personal hermeneutic process in which an interpretation of my own professional being, experience, reflections and actions might surface themes worth COMMUNICATING with my colleagues. I would in the process, face many contradictions in my established way of thinking and sense making. Mc Donald (1988) suggests, "*The fundamental human quest is the search for meaning and the basic human capacity for this search is experienced in the hermeneutic process, the process of interpretation of the text (whether artifact, natural world or human action). This is the search (or research) for greater understanding that motivates and satisfies us ... The act of theorizing is an act of faith, a religious act ... It is an expression of the humanistic vision in life*" (p 105, 110).

I am passionate about occupational therapy and deeply convinced of its capacity to contribute significantly to the health of society and to the humanistic vision in life. I am equally concerned about our historical lack of power to carve a significant niche for the profession in the face of medical hegemony, drastic financial constraints and socio-political upheaval. Our resilience in the modern practice contexts of South Africa seems to be waning. The upheaval of society following the first democratic election in 1994 brought the profession's crisis into stark focus. I was also aware of a fundamental resistance to political mobilisation, and to an exploration of our failure as a profession to challenge the iniquities of apartheid, that had prevented the majority of South Africans from realising their own humanistic visions *in life*. Personal discussions with members of the Occupational Therapy Association of South Africa (OTASA) executive indicate that they had

experienced either significant apathy or active resistance, amongst members, towards the drafting of a submission to the Truth and Reconciliation Commission Health Hearings. OTASA had initiated significant transformation in its executive and were keen to strengthen their resolve in addressing inequity in the profession, by promulgating a submission that would reflect a united commitment to fundamental change. They did not have much success.

I began to see the memorial lecture as one of a number of strategies to encourage and mobilise the profession to make sense of its historical and contemporary experience. In the dialectic, my own conscience and practice had begun to turn against the old way of doing things. Could I find a conceptual framework that would guide the development, not only of my ideas, but also of new possibilities for experiential learning and action within the profession?



Entering the THINKING Moment (*dialectic: not having enough/having too much information*)

Capra (1982), Kuhn (1970), and McGill and Weil (1992) provided the answer with their exploration of the notion of "*paradigm shift*" in which a profound change in the thoughts, perceptions and values that form part of a particular vision of reality, is seen to re-orientate people to what is important, legitimate and reasonable. Reflection on the patterns of assumptions, values, concepts and propositions that underpin a particular worldview, would lead to "*perspective transformation*" (Mezirow, 1978) and eventually to changed behaviour. Such transformations can be sudden or they can proceed more slowly "... by a series of transitions which permit one to revise specific assumptions about oneself and others until a stage occurs in which the assumptions become transformed" (Mezirow, 1985: 142). Transformation began to emerge as a possible central theme for the memorial lecture. It was also a national agenda precipitated by transition to democracy and highlighted, in particular, by the Truth and Reconciliation Commission's (TRC) role in challenging an entire nation to search for greater understanding of the motives for past behaviours and responsibilities regarding future actions. Transformation on its own was, however, too broad, I had to identify the focus of transformation.

A particularly important catalyst for my reflection at this stage was the "Mental Health beyond the TRC Conference" held by the Medical Research Council in Cape Town, on 7-8 October 1998. Broad topics addressed were: apartheid, discrimination and mental health, providing mental health services to survivors, the psychology of perpetrators and the prevention of future human rights abuses. Condensed and brought into stark focus, were many of the core issues I had been grappling with for years at a personal and professional level: my own morality and the latent perpetrator lurking within, the primacy of moral and spiritual offences in the causation and healing of psychic injury (Shalev, 1998) and health professionals' complicity in human rights abuses. I was

particularly challenged as a senior occupational therapist/leader in South Africa, and I offer the following extensive quote from Chapman and Rubenstein (1998), as it captures a challenge I felt committed to take up. It also clarifies why ethics emerged as another central theme in the memorial lecture, and how I became interested in undergraduate occupational therapy ethics education.

“Leadership is a critical factor in the determination of health policy and also serves as an example for health practice. Leaders within the health sector not only failed to recognize the relevance of human rights in health; they neglected to develop comprehensive codes of ethics or to enforce established codes of ethical conduct, and they failed to support and protect health personnel who took considerable risks in supporting human rights.

Many leaders within the health sector have provided the TRC with unqualified apologies for the conduct of health personnel during the era of “complacency”, but how is one to believe that such conduct will change without evidence that the leadership within the health sector has also changed. The health sector hearings of the TRC clearly demonstrated little evidence of such a transformation on either level. Apologies and talk of building a “culture of human rights” are likely to become the instruments of surviving “transformation” intact, rather than promoting the health and human dignity of all South Africans. Furthermore, not one leader of a health professional organization or health regulatory body, nor SAMS, nor the Department of Health has offered a strategy to include human rights in health education. Without effective reform of the leadership that was responsible for the health sector’s shameful silence and inaction under apartheid, the health sector’s stunning opportunity for transformation may simply evaporate.” (p 126)

Although the TRC hearings were restricted to only two days, they raised a range of fundamentally important questions about health professional socialisation and the centrality of ethics in facilitating the assumption by health professionals of responsibility for their conduct. I had seldom heard any of these issues discussed in occupational therapy circles and they certainly were very rarely (Katzenellenbogen, 1989; Randall, 1991, Coetzee, 1992) overtly addressed in the South African Journal of Occupational Therapy. I was equally intrigued by the complete lack of reference in Chapman and Rubenstein (1998), to disability as a human rights issue emerging from the health sector hearings which they were commissioned to document. Abuses did occur in rehabilitation settings and severe disabilities (both mental and physical) did result from political violence, yet their implications for a disability human rights agenda in South Africa were not addressed.

I followed up this query with Len Rubenstein (personal communication, 27 January 1999), sharing my concern that a medical rather than social, definition of health seemed to determine the author’s interpretation of human rights violations and that the voice of rehabilitation health professionals and, for that matter, disabled victims of apartheid abuses, had not been reflected in their findings and recommendations. My concern was primarily a missed opportunity for the disability lobby in this country.

His reply was,

“... as someone who has spent 15 years of my life in the disability advocacy field in the United States, I very much agree with what you say. The conceptualisation of disability not only among the public but among health providers, leaves a lot to be desired, particularly in the devaluing of the person with the disability and seeing the job of the health field as getting rid of the disability rather than addressing the needs of the person with the disability. Rehabilitation, accommodation and integration have not made their way into the thinking of many health professionals. It is not a good excuse, but the only reason we did not discuss disability – or some other key issues, including violence against women – was a matter of time and resources. We barely scratched the surface on mental health, and of course nothing on the larger disability issues. Everything you say deserves to be heard, and I regret that we were not able to cover the issues in our report. There is another dimension here, of course. The field of human rights has, until very recently, paid little attention to disability, even institutionalisation. Most of the focus was on narrow issues like the political use of psychiatry rather than the routine discrimination and devaluing of people with disabilities. That is true everywhere in the world. The field is just beginning to change, and very slowly.”

It was becoming increasingly clear that I was on the right track in identifying ethics as a focus for transformation and that I could possibly introduce disability and definitions of health as broad issues on which to build various examples. I was reading too widely at this stage and feeling very overwhelmed by the volume of information that is available. To negotiate the dialectic, I had to develop a plan to retain focus.



Entering the PROJECT Moment (*dialectic: plans are not enough/no plan can be perfect*)

The next step was to frame the problem more clearly through a focussed exploration of available contextual and literature evidence. The following picture unfolded:

South Africa is emerging from decades of systematic human rights violations that have impacted on every aspect of civil society, including the health sector. The widespread allegiance of the health professions to apartheid ideology has been exposed by submissions to the Truth and Reconciliation Commission (TRC) Special Hearings on the Health Sector in June 1997. (Health and Human Rights Project, 1997; Chapman and Rubenstein, 1998) These submissions give a striking account of how an entire health system could be based on racism, and how the culture of apartheid could result in human rights violations through erosion of health professionals' ethical accountability. Silence and inaction in the face of injustice and human rights violations must have involved moral choice, given the existence of moral codes and guidelines for professional conduct. Some submissions suggested that violations occurred because of complacency and ignorance. The problem, it seems, was not the clarity of ethical codes, but that clinicians believed that codes and professional values applied only to those who were fully human, or were secondary to other

considerations, for example, laws and government policies. Essentially the violations of ethical codes seemed to have occurred because of moral insensitivity to, and denial of, the humanity of Blacks.

A human rights and social justice perspective considers humans to be of equal worth with equal moral right to participate in society, regardless of gender, age, race, culture, sexual orientation, disability or socio-economic status. Codes of ethics and professional conduct have historically evolved within limited disease-based and patient-centred conceptualisations of health (Seedhouse, 1991) and have not been applied to broader concerns such as social justice or to the physical, psychological and social health consequences of human rights violations. Chapman and Rubenstein (1998) suggest that *"when health concerns are limited to the objective of curing disease and healing impairment, the likelihood increases that health professionals will not relate in a holistic manner to issues relating to the human worth and dignity of their patients. Such moral disengagement may be a critical factor in abusive behaviour."* (p 127)

Underdeveloped moral and ethical reasoning and professional socialisation within an apartheid ideology, and adherence to ethical codes as rules supplementary to the law, may have predisposed health professionals to collude in the systematic denial of human rights to the majority of people in South Africa. *"Most violations of human rights in health took place in grey zones. The characters were not heinous villains, but ordinary people doing their jobs in a system that hid its flaws beneath a veneer of professionalism."* (Baldwin and De Gruchy, 1998, unpublished) This veneer was challenged by Coetzee (1992), who suggested that occupational therapists placed their professionalism above human rights and used it as a cloak to cover up disengagement from ethical accountability.

In 1987, a delegation from the World Federation of Occupational therapists (WFOT) visited South Africa to investigate occupational therapists' functioning under apartheid, and to make recommendations regarding the profession's inclusion or isolation from international support. The delegates found South African occupational therapists to be exceptionally competent and non-discriminatory in their therapeutic capacity but very apathetic in their political activism. Therapists were not, it seems, sensitised to the imperative of professional accountability, beyond the care of their individual clients, and to the populations of clients living in conditions counterproductive to health and wellness. Seedhouse (1988) distinguishes between dramatic ethics, (for example, life threatening events such as abortion and euthanasia), persisting ethics (for example, issues underlying dramatic ethics) and general ethics (for example, day to day behaviour and how to live and act to the highest moral standard). Occupational therapists are mainly concerned with day-to-day ethics (Barnitt, 1993) and were not equipped to deal with, or were desensitised to, the dramatic or persisting ethical issues associated with social injustice and human rights violations. It would be

reasonable to argue that they may still be equally ill equipped or indifferent now to ethical dilemmas and human rights violations that arise in a *"rapidly changing health scenario where contemporary health issues continually confound us with regards to their ethical and human rights implications."* (Baldwin and De Gruchy, 1998, unpublished)

Professional guidelines specify "what to do" and "how to behave", yet despite such comprehensive background information, ultimately therapists still have to rely on their own resources, reflective thought and problem solving ability. (Barnitt et al, 1998: 52) These authors used two case studies to illustrate the ethical dilemmas involved with truth telling (veracity) and the right to resources. They argue that despite strategies such as reference to a Code of Ethics, knowledge of professional conduct, and an understanding of the theories and principles that underpin healthcare ethics, therapists still find situations where problem solving skills and sound reasoning determine the way forward. However, *"therapists are human and, inevitably, 'bad' decisions will be made at times because duty or consequences of actions have either been ignored or are in conflict."* (p 56) They argue that the crux of morality for the professional lies in the praxis between knowing what is right and doing what is right. No single "right" or "wrong" position exists but the ability to make informed decisions is seen to depend on the explicit development of moral and ethical reasoning.

Virtue and moral development theory informs contemporary ethics education of health practitioners by suggesting ways to improve the quality of thought about moral and social issues; integrating moral thought with moral action and alleviating problems associated with the indoctrination of values rooted in prejudice, intolerance, narrow mindedness and rigidity. (MacIntyre, 1981; Flores, 1988; Rest and Narvaez, 1994) A virtue is defined as *"an acquired human quality the possession and exercise of which tends to enable us to achieve those goods which are internal to practice and the lack of which effectively prevents us from achieving any such goods."* (Salsbury, 1992: 155)

Where honesty, impartiality, integrity and other similar virtues are the norm, the life of the professional, the profession and society is seen to be enriched. It is believed that deliberately cultivated virtues and morality foster the power which health professionals need if they are to counteract the negative influences pervading healthcare systems. Contemporary ethics education must therefore, according to Rest and Narvaez (1994), focus on the moral sensitivity (interpreting the situation), the moral judgement (judging which action is morally right/wrong) and the moral motivation (prioritising moral values relative to other values) and the moral character (having courage, persisting, overcoming distraction, implementing skills), of the practitioner. Was there, I wondered, scope here for us to begin redressing the attitudinal inequities of racial bias and other forms of discrimination in undergraduate Occupational Therapy education?

Although major developments in moral, political and educational philosophy in recent years have resulted in an overwhelming amount of literature addressing the moral and ethical development of professionals such as doctors, teachers, nurses, architects and engineers, very little seems to have influenced South African occupational therapy literature or educational discourse. To date it has addressed only the specificity of the profession's code of ethics (Watson, 1989; Concha, 1993; Jooste, 1991). This specificity focuses mainly on the principles that regulate clinical encounters of occupational therapists with individual, or groups of clients, and guides the resolution of ethical dilemmas that arise within a disease paradigm or between individual practitioners and the public or colleagues. No article specifically addressing quantitative or qualitative issues of moral and ethical development and education, or the ethical dimensions of professionalism, human rights and social justice, has yet appeared in the South African Journal of Occupational Therapy. The dialectical impetus here was to begin engaging others in my process of learning. Could my colleagues help me to understand the existence of this apparent paucity?



Entering the ENCOUNTER Moment (*dialectic: disconfirmation is more valuable for learning than confirmation*)

I decided to do a telephonic survey of the ethics curricula of some occupational therapy training institutions to get an idea of approaches to ethics education. Having interviewed four lecturers responsible for various ethics courses available in the country, I found that:

- ◆ Curricula followed a similar pattern in which students are: in first year, introduced to the professional code of conduct and the basic concepts of professional ethics, in second year; orientated to professional behaviour in fieldwork, in third and fourth year, expected to demonstrate cognisance of practical ethics and application of ethical reasoning in fieldwork and, in fourth year, revision of the philosophy of professional ethics. The average didactic input on ethics during the four-year degree programme is eight hours. The occupational therapy department at the University of Cape Town follows a different approach. This is presented in the epilogue section.
- ◆ Training institutions either use a generic professional oath in conjunction with other health disciplines at graduation, or have developed their own departmental oath that graduates take prior to receiving their degree and a graduate badge. None of the programmes interviewed explicitly review the implications of the oath with their graduates before it is taken, nor are graduates directly involved with crafting the oath to which they confirm allegiance. The occupational therapy department at the University of Cape Town, has in the past two years, engaged the graduating class in developing their own oath.
- ◆ The development of professionalism is seen to be a tacit phenomenon woven into the fabric of lectures or fieldwork expectations and evaluations. Students receive feedback on their professional conduct according to a set of criteria based on standard rules for

professional behaviour. Few explicit structures beside clinical supervision and role-modelling seem to be in place, for example, discussion groups, journals, in which students can resolve ethical and moral dilemmas that arise in practice. Dialectical exchange about professional virtues, personal morality and values, and moral motivation usually occurs in individual feedback, for example, the student's fieldwork evaluation form, or more generally, in classroom discussions. The occupational therapy department at the University of Cape Town is in the process of revising its criteria for the evaluation of student professionalism.

- ◆ Human rights and social justice have only recently begun to be addressed as a result of a growing disability lobby and the development of community based rehabilitation. Few of the training centres involved occupational therapy students in multidisciplinary undergraduate debate on ethical issues of mutual concern. Students from the UCT Faculty of Health Sciences participate in weekly discussion groups at multi-disciplinary fieldwork sites.

In the light of these findings, I wondered whether a substantive national transformation of the undergraduate ethics curriculum was indicated? I then examined the status of ethics in occupational therapy education internationally.

The TRC Health hearings point out that tertiary educational institutions failed to ensure that students engaged with, and internalised, principles of ethics and human rights in healthcare. *London and Mc Carthy, (1998)* note that " ... central to the many recommendations contained in submissions to the hearings was the urgent need to improve the ethical and human rights orientation of undergraduate and postgraduate training in the health professions." (p 257). *Seedhouse (1991)* perceived the teaching of medical ethics to be a sham, and of little help in informing students as to "where and how to find ways ahead for themselves" or in determining "how best to conduct one's life in the presence of other lives". (p 281) This last is, in his opinion, the founding question of ethics. *Barnitt (1993)* suggests that the teaching of ethics has been in a decline because of a widening gap between moral philosophy and the concrete realities of life. She became concerned about the problems that students in allied health professions were encountering in their clinical fieldwork experiences. She undertook a survey to determine the status of ethics teaching in the United Kingdom and found that there appeared to be an inconsistency of understanding in relation to what should be included in ethics programmes. Her research also revealed that educators did not know how to convey such content to students.

Pennington and Bagshaw (1992) identified the requirement for ethical reasoning in occupational therapy education with regards to research and student projects. In conducting a literature search in the field, they found " ... only a few authors ... have discussed ethics in relation to occupational

therapy curricula and that authors may stress the importance of ethics in practice, none seem to address how educationalists could facilitate the development of ethical decision-making skills." (p 419-422)

There is a growing body of literature attempting to address this hiatus. Educators in contemporary society recognise the need for professional practitioners to be morally mature and active as individuals and as professional associates, if they are to be less dependent on rules and regulations to guide their practices. (Rest and Narvaez, 1994; Brockett et al, 1997).

Research currently being undertaken at the Faculty of Health Sciences at Mc Master University examines the moral reasoning processes of students in occupational therapy and physiotherapy. (Brockett et al, 1997) This is done first on admission, and again upon completion of their programmes. The Defining Issues Test (Rest, 1987, quoted in Rest and Narvaez, 1994) is used as a baseline measurement. Preliminary data suggest that many students are entering the programmes with well-developed moral values associated with a democratic society and consistent with a traditional approach that sees professional ethics as supplementary to law. However, there seems to be little regard for the influences of personal moral values that Koniak (1996) believes to be desirable in a contemporary account of ethics. Koniak argues for a new conception of the relationship between law and ethics. She suggests that, instead of the common perception that ethics takes over when the law is deemed inadequate, the law should be seen as being informed and challenged by ethics and morality. The problem with the commonly understood approach to ethics for members of the professions, according to Koniak, is that it is inconsistent with the self-regulation associated with professionalism. Personal morality must regain a place in meeting legal and professional demands. Law, ethics and morality must all speak to conduct that is legally seen to be either *right or wrong*. Brockett et al (1997) are attempting to reinstate morality as a core component of ethics education – they see moral reasoning as informing professional ethics and both in turn, contributing to the law. Their research aims to demonstrate the different effects of traditional and contemporary ethics education on the moral reasoning processes that students use in reaching moral judgements.

London and Mc Carthy (1998), responding to the call to place human rights and medical ethics on the agenda of institutions training health professionals in South Africa, report the results of a retrospective cohort study in which they compared, by survey, the ethical and human rights knowledge and attitudes of participating fourth year medical students with those of a matched group of control students. Students in the experimental group volunteered to participate in a five-day course aimed at providing them with an appreciation of the circumstances under which human rights violations could occur, and the role that health professionals can play in combating such

abuses. Teaching methods included panel discussions, field visits to prisons and police cells, and intensive group work.

The results demonstrated clear benefits for *"improved knowledge about the ethical dimensions of human rights and some less tangible attitudinal benefits. Of particular relevance is the attitude measures on a priori assessment of importance format. It offers some insights into potential ethical domains of human rights concerns in the field e.g. understanding psychosocial problems experienced by exiles, counselling torture survivors and knowing laws protecting prisoners' healthcare."* (p 261). The authors acknowledge that quantitative estimation of attitude is notoriously problematic in capturing meaningful data. They recommend the further extension of similar courses to a wider audience and they alert the medical profession to pay greater attention to teaching the ethical dimensions of human rights.

Christakis and Fendtner (1993) suggest that medical educators have focussed on what the core curriculum should include, how material should be taught and how it should be analysed, for example, using ethical principles, normative moral reasoning or legal theory. Little attention is, given however, to the ethical issues that medical students *"actually confront and the impacts the resulting dilemmas might have on the students as they adapt to the clinical world and decide about their own conduct and role. In other words, current thinking does not situate medical ethics education within the context of students' ongoing ethical development."* (p 249) The authors, in response to these concerns, developed a thematic taxonomy of medical students' ethical dilemmas, through a systematic review and content analysis of written cases submitted by students as part of a 'ward ethics' discussion session. The recurrent, problematic themes that emerged were: the students' pursuit of experience, differing degrees of knowledge, ignorance among team members and dealing with disagreement within the hierarchical authority structure of the medical team. Students were able to grapple with these dilemmas in a participant-driven group discussion approach to teaching ethics. The authors contend that *"ethics presented as moral theory or a set of principles can go only so far: personal problems, culled from the daily events of students' lives and rooted in the complex social situation of the ward, more thoroughly capture their consciences. It is in making decisions and living with their consequences that ethics ceases to be only a theoretical discipline and begins to become a professional code of conduct."* (p 254) Their view is endorsed by Osborne and Martin (1989), and Bickel (1991) who suggest that if medical students are not given the opportunities to discuss and think through the anxieties associated with the ethical issues that face them in day to day practice, they will as qualified medical practitioners, adopt stereotyped and limited responses to the ethical aspects of their work.

The dialectic within the encounter moment resides in the learning that takes place through the disconfirmation, rather than confirmation of one's ideas. During this period, I ran an ethics

workshop with the final year occupational therapy students from UCT and the University of the Western Cape. This was one of a number of experiences of disconfirmation. Having gained a lot of theoretical knowledge about ethics, human rights, disability rights, social justice, professional values and personal morality (amongst others), I now had to integrate my own clinical experience into ideas that made sense to the class. I also had to create opportunities for the class to share their ethical dilemmas and to guide them through ethical and moral reasoning processes. Many of my ideas were disconfirmed and I recognised my need for a much deeper comprehension of ethics and human rights in practice.



Entering the MAKING SENSE Moment (*dialectic: reduce data to understandable simplicity/expand connections between data*)

Schön (1983) described reflection as the means by which the complex epistemology of practice may be uncovered and as a means for the development of professional competence and expert judgement. An extensive amount of literature on reflection and the use of reflective journals as a valid tool for assessing students' accomplishments of learning exists. (Schön, 1983, 1987; Mesirow, 1991) In occupational therapy literature the work of Mattingly (1991) and Fleming (1991) on clinical reasoning is seminal. These authors view reflection as one source for enriching the reasoning capacity of occupational therapists.

At this stage I wanted to make sense of the rich data that lay untapped in the fieldwork learners' logs which UCT occupational therapy students keep as part of their clinical learning. My colleagues Buchanan, Moore and Van Niekerk (1998), document the writing strategies used by these students to capture their intervention plans, outcomes, experiences, and reflections on their fieldwork learning. Could I gain some understanding from these textual documents and in particular, from their reflections on the ethical dilemmas that they face in the daily events of their lives in the field? How morally sensitive are they? Could I learn something about their moral motivation? What are their perspectives on ethics education?

I developed and submitted a research proposal to the Research Ethics Committee of the Faculty of Health Sciences at UCT to investigate these questions through qualitative content analysis of students' fieldwork learners' logs. I also aimed to analyse the content of focus group discussions on student ethical dilemmas during fieldwork, in relation to their clients, colleagues and the context in which they worked. It was accepted in March 1998. I subsequently conducted one-hour focus groups with 6-8 final year occupational therapy students from each of the three local universities in the Cape Metropole. I also ran one focus group of six clinical tutors and obtained access to third and fourth year U. C. T. students' fieldwork learners' logs. The results of this research will be published in due course. A superficial analysis of what I was hearing in the groups and gleaning from the learners' logs correlated strongly with some of Barnitt's (1993) findings. She conducted a

preliminary investigation of thirty-five occupational therapy and thirty seven physiotherapy clinicians' and students' moral problems in practice and found their current concerns in rank order to be:

- ◆ Ineffective treatment
- ◆ Unethical/incompetent colleagues
- ◆ Priorities in treatment

Local students also expressed concern about:

- ◆ The futility of treatment , given the volatile socio-political context of South Africa, the reduction of hospitalisation and the almost complete lack of community based follow-up services.
- ◆ Frequently having to treat patients, in the face of their own inexperience, without the direct supervision of clinicians, and in the absence of role-models resulting from post reductions.
- ◆ Cultural barriers caused by differing worldviews, language and life experiences between themselves and their clients. (These findings launched me into an extensive literature search on the influences on professional canons of knowledge, alignment of professional methods to local realities and the need for an African professional identity. These dimensions are *reflected in the lecture and may lead to future publications.*)

I have, as yet, insufficient understanding of the themes emerging from the textual data to comment meaningfully. The concerns expressed in the focus groups yet again highlighted the influence of macro contextual (socio-political, economic, cultural) issues on ethical and moral dilemmas of health professionals in the field. I knew I had to introduce these into the memorial lecture, but wanted to do so in a way that would capture the audience's attention and moral imagination.

I was using Mark Johnson's (1993) work on moral imagination to analyse the students' learners' logs and was progressively intrigued by his views on metaphor and imagination in ethical deliberation. He suggests *"the metaphors that make up our shared moral understanding – our 'folk theories' of morality – are held in common by all of us within a moral tradition, and they are part of what makes it possible for us to inhabit a shared world"* (p 3). With this in mind, I searched the local bookshops for African poetry that might capture some of the contextual imagery needed to frame my ideas. Slattery (1995) sees poetry as *"the natural response to the mystery of the universe, not measurement and codification. ... for in poetry, narrative and art we can understand the self as continuously being reconstructed in new and ironic ways in every social and cultural milieu"* (p 264).

I discovered a poem by Heather Robertson (1991) in a book of reflections, essays, illustrations and stories on the theme of hope. It was written by a number of South Africans at a time, leading up to the first democratic elections - a time of despair and hopelessness in South Africa. Like so much of what I was reading at that time, this anthology precipitated much deep reflection about the occupational therapy profession in Africa and influences on its development. I was struck by the recurring reference in the various books I was reading to post modernism, deconstruction of dominant Western paradigms and the influence of the feminist, and other minority movements. In keeping with the qualitative research paradigm, I kept a journal of my thoughts about occupational therapy in contemporary South Africa. The dialectic at this point was the hard work of making sense of what was happening to the profession collectively. (I have not included any of these concepts as they fall outside the focus of this dissertation.)

Three events that were particularly helpful at this time in validating my thinking and in confirming the reliability of my sense making were:

1. Dialogue with Professor John Williams, a visiting ethicist from Canada, who was on sabbatical in the Department of Medicine at the Faculty of Health Sciences. I was alerted to the role of professional structures in promulgating an ethics agenda. He suggests that ethics be incorporated into institutional or collective professional decision-making by:
 - ◆ Awareness: the ethical dimensions of decision-making, for example, resource allocation.
 - ◆ Commitment: making the inclusion of ethics an explicit element of decision-making.
 - ◆ Education: developing the capacity of decision-makers to solve problems ethically.
 - ◆ Structure: setting systems and procedures such as ethics officers, ethics audits and checklists in place.
 - ◆ Programmes: development of multi-level objectives and strategies within the various dimensions of an organisation.
 - ◆ Communication: multi-directional so that everyone is involved.
 - ◆ Accountability: regular feedback on progress

I used these perspectives to clarify some of my thinking about the ethics structures within the profession. His framework for ethical decision making also seemed useful for the development of the undergraduate ethics curriculum. The credibility of ethics education would be enhanced if all role-players were part of an explicit agenda such as the one proposed by Professor Williams. (Roy et al, 1993)
2. A tape-recorded free attitude interview (Meulin-Buskins, 1997) with Professor Ruth Watson, in which she helped me to bracket my subjective opinions and feelings about ethics, morality and professionalism. Pinar (1976) quoted in Slattery (1995) writes, "*bracketing what is, what was and what can be, one is loosened from it, potentially more free from and hence more free to freely choose the present. This bracketing allows one to*

juxtapose the past, present and future and evaluate the complexity of their multidimensional interrelations” (p 57).

This exercise began to introduce qualitative criteria for research validity and reliability into the early stages of my investigation. An audit of this kind, at regular intervals in the research process, will continue to increase the credibility and dependability of my findings as I further analyse the data. The interview also helped to clarify the progress I was making (or not making) in conceptual analysis of emerging themes, and to begin mind mapping a possible framework for the memorial lecture. I was beginning to view the lecture as one of a number of strategies, both in the ethics research I was doing, and in sensitising the profession to a revised ethics agenda.

3. Participation in an exceptionally enriching Masters research discussion group in which our debate on core professional issues and constructs broadened my thinking horizons and disconfirmed (as in the dialectic) many of my ideas. My colleagues were particularly helpful in refining my conceptualisation of the changing ideology of occupational therapy practice in a developing country. The group introduced member checking (Lincoln and Guba, 1985) for my evolving research protocol. They were also helpful in honing the initial mindmaps and drafts of the memorial lecture.

The following quote from Alan Smithson’s (1997) perspective on the possibility of transformation captures something of my educational experience at that time.

“ ... there is that within us which is capable of a transformation beyond our wildest imagining, and that this potential is held in check only because our vision is too clouded, our words and thinking are too stereotyped, and we are unwilling to take the plunge of faith when the moment comes. Nothing except what theologians call ‘grace’ – the spontaneous opening of ourselves to the absolute for which we can be glad and even joyful but cannot ever claim credit – can enable us actually to take the plunge. But a true vision can enable us to see the situation as it really is and can give us a framework which will help us to orient and channel our desire.” (p 276)

The dialectical challenge was to reduce all the information that I had gathered into manageable form without being so succinct that I lost its richness.



Entering the COMMUNICATION Moment (*dialectic: get information more clearly expressed/ impossible to communicate with anyone outside of the experience*)

At this point, I began to write the first drafts of the lecture. It could at best paint a landscape of uncharted South Africa occupational therapy territory and in so doing, signpost possible directions for further deeper exploration. The dialectical dilemma at this point was how to communicate everything that I had learnt to people who had not been part of my experience. I developed the following framework for this landscape, recognising that I could not, in a public address of approximately one hour, cover any one of the domains in great depth.

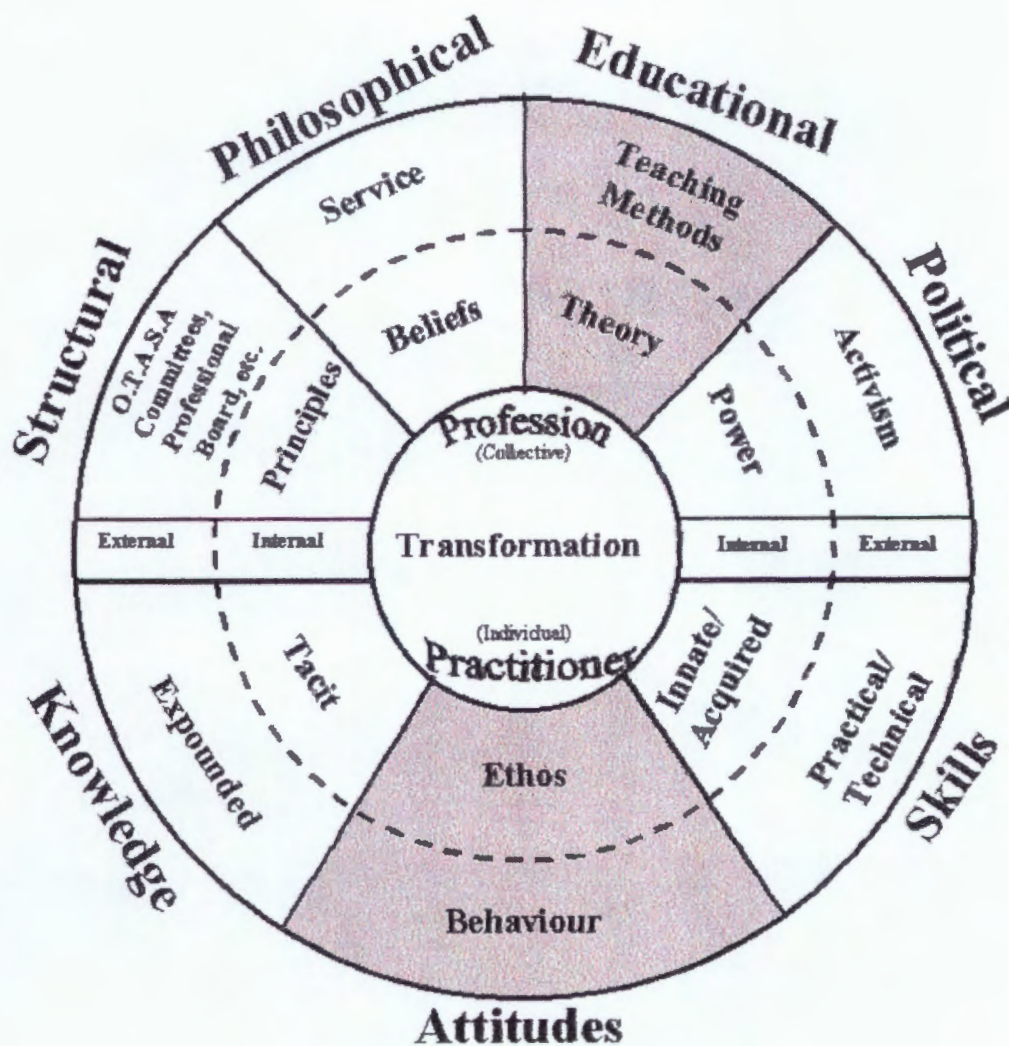


Figure 2 – Dimensions of Transformation

This framework depicts some of the collective and individual professional domains within which I believed a 'perspective transformation' (Mezirow, 1978) was indicated in light of the following problem statement. (The shaded domains form the focus of this minor dissertation)

Problem to be Addressed by the Lecture

South African occupational therapists have, by the paucity of information on ethics and human rights in their literature, practice and education, and by their apathetic response to the TRC Health Sector Hearings, failed to demonstrate awareness of the importance of human rights in their professional ethics and moral actions.

Purpose of the Memorial Lecture

To sensitise South African occupational therapists to the need for transformation in contemporary South African occupational therapy practice and education.

The Aims of the Memorial Lecture

1. To present an overview of the collective and individual professional domains within which transformation is indicated.
2. To draw attention to historical and contemporary influences on the profession's ethical responsiveness to emerging contextual challenges.
3. To stimulate individual and collective reflection amongst occupational therapists about professional accountability and relevance, in a democratising healthcare system.
4. To precipitate change in occupational therapy ethics education.

The 28th National Congress of the Occupational Therapy Association of South Africa (OTASA)

The Vona du Toit Memorial Lecture was presented at the 28th National Congress of OTASA on 15th July 1999. The theme of the congress was 'metamorphosis, transformation, adaptation, change.' The organisers' question to delegates was "*as we approach the new millennium, are we equipped as a profession to face the challenges facing us? 'We need Foresight, Forethought, Foreknowledge for Now.'*"

The keynote speaker, Jennifer Creek from the University of Teeside, United Kingdom, addressed the links between the evolving professional identity of occupational therapy and the nature of contemporary knowledge, power and language. We had never met before, nor been in contact, yet were speaking with one voice.

She also ran a workshop on the philosophy of occupational therapy in which she:

- ◆ Identified the shared beliefs and values of occupational therapists worldwide.
- ◆ Explored, with participants, the unique aspects of occupational therapy philosophy in South Africa.
- ◆ Demonstrated how professional beliefs and values direct the development of occupational therapy theory and practice internationally, nationally and locally.

- ◆ Discussed the importance of philosophy in maintaining and promoting a strong sense of professional identity and a positive image of the profession.

The memorial lecture was attended by approximately one hundred and fifty occupational therapists. There was one Black person in the audience. My vision for the profession seemed untenable. When would we have a Black disabled male (we are a predominantly female profession) receiving the award and reading his address to a large multiracial audience of occupational therapists; and members of the communities we serve? Only then would transformation truly have begun. The communication moment had arrived. The dialectical challenge was to share my understanding in such a way as to precipitate shifts in the BEING moments of the audience.

The 17th Vona du Toit Memorial Lecture

The 17th Vona du Toit Memorial Lecture

OUR BIT IN THE CALABASH

Thoughts on Occupational Therapy Transformation in
South Africa

I am deeply honored by the opportunity to give this 17th Vona du Toit Memorial Lecture. My sincerest appreciation is extended to all those who helped me along the way to achieving this honor. My family, colleagues, students and especially those who taught me the most, the people who shared their hopes and struggles with me as an occupational therapist.

I had the privilege of being taught by Vona during the last few years of her life. A vivid memory is my fascination with her thinking around human volition, creativity and the philosophy of occupational therapy. We explored the meaning of core professional constructs such as holism, independence and participation. We were introduced to the ideas of Carl Rogers, Erich Fromm and Paul Tournier during her interpersonal skills lectures. I specifically recall discussions on Martin Buber's notion of existential meaning derived from having affirmed another, having answered another's plea for community, of having entered an I-thou relationship¹. Vona taught us to explore within ourselves to develop the initiative for creative service beyond ourselves as occupational therapists in this country. She defined initiative as "a quality of self application and direction in a new situation." The confounding complexities of the new South African context require a fresh application of initiative and creativity in affirming the heart of occupational therapy. Our bit in the calabash of a new society should be the ethos of the profession shaped by the emerging possibilities of our African location.

Our Bit In The Calabash

I chose to use Heather Robertson's poem, "Our Bit in the Calabash", as for me it resonates with metaphors that are relevant to occupational therapy in a democratising society.²

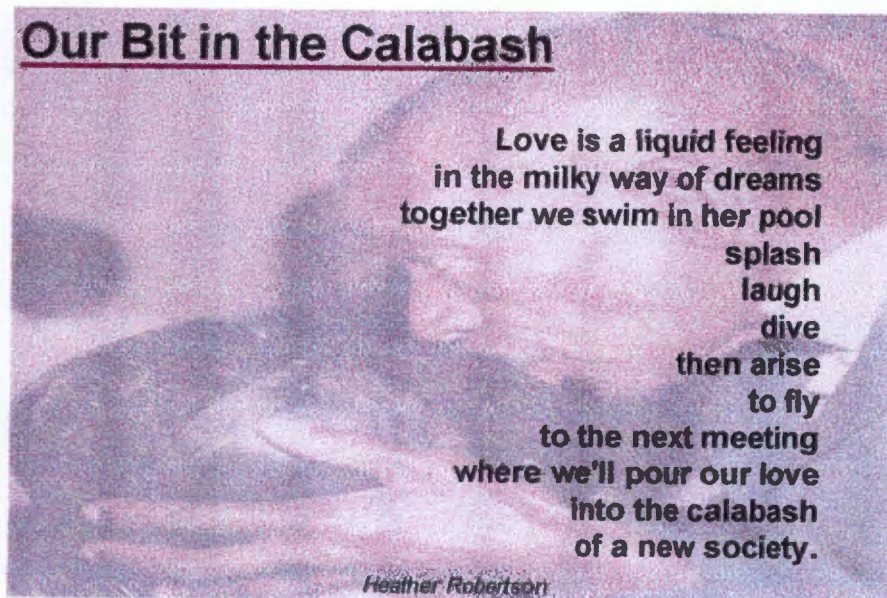


Figure 3 Our Bit in the Calabash

A calabash, a hollowed out gourd, is a traditional African vessel used for drinking. At social gatherings it is filled to the brim with home brewed traditional beer and passed from person to person as a communal cup. Drinking from the calabash in this way confirms one's place in the clan and strengthens the interdependency and common ethos that binds the collective.

The metaphor of love speaks to me of the heart or ethos of occupational therapy through which the profession can take its place amongst the moral leadership for social transformation in South Africa. Democracy has opened up unprecedented opportunities for occupational therapy to reaffirm its social responsibilities and to contribute its bit to the renewal of society.

The words swim, splash, laugh and dive remind me of the realities of everyday practice and of the external dimensions of our professional identity. We have all dived into despair at the high crime rate, dwindling resources and overwhelming needs of our clients. We have also laughed with exhilaration at the accomplishments of our clients who arise to meet the challenges of life despite extraordinary odds. We have swum and splashed our way through countless meetings to develop drafts of green and white papers culminating in progressive, liberating policies and strategic plans for every conceivable facet of civilian life. Transformation has become a national agenda which has also challenged us to re-examine the collective social power, economic gains and political rewards of the profession and its potential to fly to new practice horizons.

Living and working in the calabash of a new society in recent years has challenged most of us at one time or another to ask fundamental existential questions about human dignity and freedom, the nature of human action, self-determination and co-existence. We have been forced by the tumultuous changes in our nation to take stock of our personal and professional beliefs and values and consequent actions.

None of us has come out unscathed by the ravages of apartheid so we all have a stake in the process of reconciliation, reconstruction and creating a caring humanity for all. We can learn from the past by examining the foundations on which we positioned ourselves as health practitioners in relation to human suffering under apartheid. We can consider where we locate ourselves now that we have a second democratically elected government, new legislation and a health sector based on the primary health care approach.

In occupational therapy too, there is a need for transformation into *"an African identity; an identity that is neither racial nor geographic, yet evolving and being shaped by Africans in confrontation with a shared set of complex historical and contextual challenges."*⁴³

South African occupational therapy is unique. Our bit in the calabash of a new society should be a distinctive interpretation of the profession's core beliefs, values and methods that reflects a responsiveness to the health needs of Africa's peoples and our African location.

My goal with this lecture is to initiate dialogue within the profession based on questions such as:

- ◆ *"What can I do as an occupational therapist towards the renewal of society?"*
- ◆ *"How can occupational therapy adapt and flourish in a health sector that is attempting to redress the inequities of our apartheid past?"*
- ◆ *"What adaptations in our professional knowledge, skills and attitudes will lead to progressive transformation?"*

The essence of transformation is to continually change to another more relevant form, substance or character in response to the demands of the context. I think we often respond to the demands of the context by analyzing what was, is and ought to be in a factual, technical sense (i.e. we focus on form) when what we should be doing, is thinking critically about what was, is and ought to be in a principled sense (i.e. focus on substance and character). Charting a course for ourselves and for the profession in the changing landscape of the *new South Africa* suggests the need for renewed understanding and affirmation of our professional beliefs, values and ethics, and how these higher ideals guide us in meeting our responsibilities towards the society we serve.

This lecture addresses the transformation of occupational therapy in South Africa in four parts. Firstly, I apply the concept of transformation to the development of the profession over time, then I explore the past features of occupational therapy practice. I consider the challenging social forces of the present which should precipitate the revisioning and attunement of the profession's internal and external dimensions and I conclude the lecture with some thoughts on transformation strategies.

Transformation: The Key To A Flourishing, Socially Relevant Profession.

A flourishing, socially relevant profession is a continually evolving and transforming profession.^{4 5} To flourish is to be in a state where no division arises between what the profession ought to do in response to Africa's needs, what it wants to do and what it is able to do. A profession's development is related to the fit between the emerging needs of society and the appropriateness of the profession's response to such needs. According to Kuhn (1970), a profession develops cyclically through four distinctive stages or periods of time.⁶

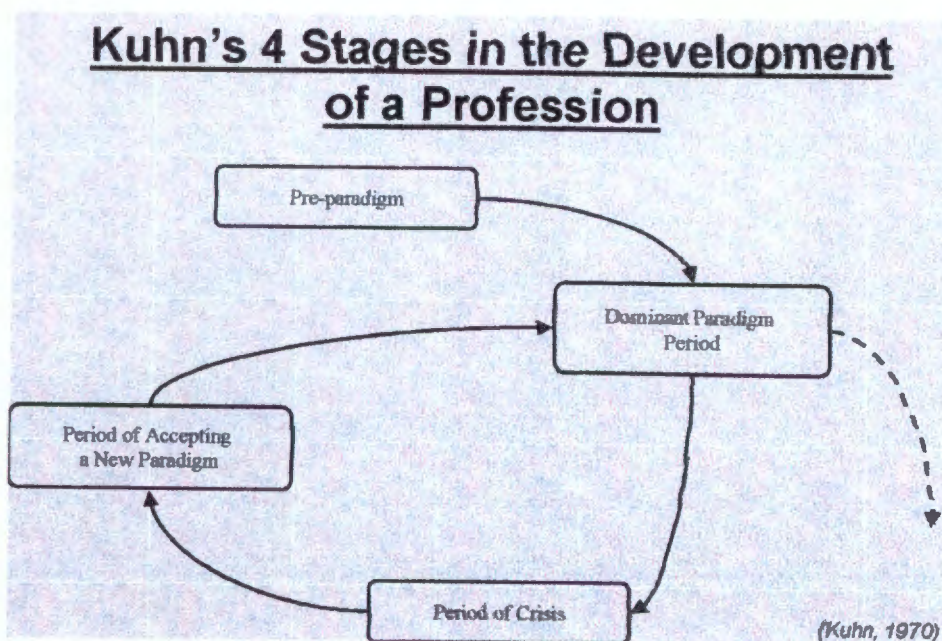


Figure 4 - Kuhn's Four Stages in the Development of a Profession. (Kuhn 1970)

The pre-paradigm period precedes the formalisation of a profession. During this period a group of people doing similar things begins to identify an emerging theoretical body of knowledge. They recognise the need for, and develop specialised education and training in order to assimilate and apply the growing theoretical body of knowledge. A formalised professional association based on a professional code of conduct and ethics is established.^{7 8}

The dominant paradigm period is a time in which the profession consolidates a strong service and research orientation based on the acceptance of a core philosophy, common purpose and distinct methodology. This dominant paradigm may not always be sufficient to meet the challenges and opportunities afforded the profession, due to changes in the context in which it is practised.^{7 8}

The period of crisis is a positive event precipitating progressive, profession-enhancing change. It comes at "a point in time in which the paradigm for professional existence and success for some reason fails the profession by leaving some major problem or problems unsolved." (Foto, 1998) This period pushes the profession to define its future and realign its ideology and methodology in response to contextual pressure. It evolves into a period in which the profession accepts a new paradigm that redefines the profession in some way. During this period a new ideology, methodology and common purpose emerges. Professions develop further through a cyclical repetition of periods of crisis and of reshaping new paradigms and worldviews.⁸ The impetus for the profession's evolution lies in the hands of individual practitioners who collectively envision and articulate its new future.

Transformation requires each practitioner to consciously work on modifying, adapting or attuning assumptions, stereotypes, prejudices and values that shape the internal and external dimensions of his or her practice.

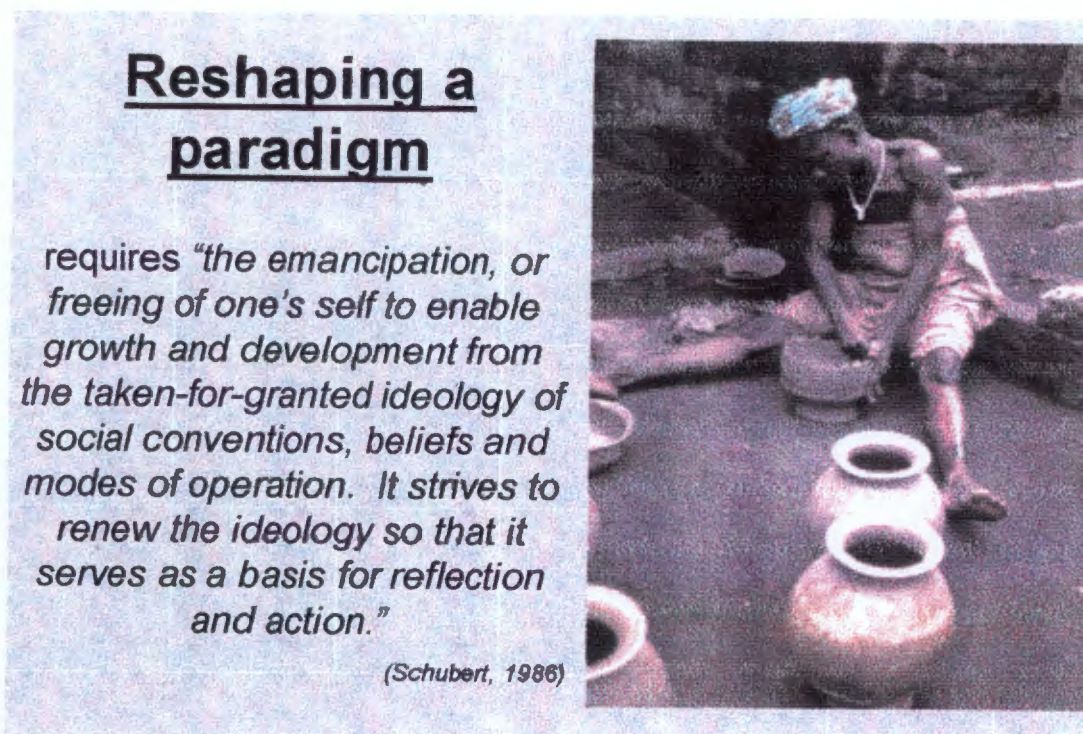


Figure 5 – Reshaping a Paradigm ⁹

Occupational therapy is at its centre, a moral enterprise, a special kind of human activity that cannot be pursued effectively without virtues such as integrity, humility, altruism and prudence.¹⁰ The breadth, diversity and complexity of occupational therapy make it almost impossible to define. It is however distinctly client-centred, directed by an ethic of care and is based on a core set of beliefs about humans as occupational beings and occupation as a basic human need. Occupational therapists value human freedom, equality, truth and dignity, and adhere to a code of ethics based on universal Georgetown principles such as beneficence, non-maleficence, veracity and justice.^{11 12}

The question arises for South African occupational therapists as to whether these professional beliefs, values and principles (mainly articulated by our American and British colleagues) reflect the values and ethics of the people we serve, the realities of practice in a developing country? Are there other values, principles and methods of practice which we should be considering and/or adopting as well? Let's consider the past to see if we can uncover some answers to these questions.

The Past: Revisioning the Dominant Paradigm

Presented here, is a summary (Table 1) of what I believe to be, the core features of our dominant paradigm.

<u>The Dominant Paradigm Period</u>	
BELIEFS AND PRACTICE	<i>Individual, client-centred practice</i> <i>Institution/hospice based</i> <i>Activity centred</i> <i>Narrow definition of health</i> <i>Medical model</i> <i>Mind/body dualism</i> <i>Bio-medical reductionism</i>
ETHICS	Traditional
VALUES	Care/moral orientation

Table 1 - Core Features of the Dominant Paradigm

The South African occupational therapy paradigm cycle bypassed the pre-paradigm period which occurred in the USA and Britain during the first quarter of this century.¹³ Its dominant paradigm period may be described as predominantly Western and medical in focus for a significant part of the profession's history in this country. The majority of occupational therapists from the '40s to the early '80s practiced in the public sector domain. These contexts were usually dominated by medical knowledge rather than occupational therapy discourse. An artificial, yet explicit, and dare I say, insidious demarcation existed between so called "physical" and "psychiatric" occupational therapists. This reinforced the mind/body dualism inherent in a narrow definition of health and saw the reduction of symptoms, the alleviation of performance component dysfunction or the acquisition of skills as the primary focus of therapy. Have you noticed, for example, that whereas psychiatric occupational therapists were in the past associated with arts and crafts, they are currently associated with life skills training? I have yet to see an advertisement inviting an occupational therapist to join a multi-disciplinary mental health practice that requires the applicant to have experience in facilitating optimal human occupation rather than experience in stress management, assertiveness and social skills training.

It is important for occupational therapists to seriously consider their bit in the calabash of the past. We not only need to learn from our mistakes but we also need to learn how to demonstrate our moral accountability to the vulnerable and marginalised in society by being aware of the ideology

for the basis for our actions. I will now expand on the dominant paradigm in terms of ethics, values, beliefs and practice and will highlight emerging new paradigm directions.

In 1987 a delegation from the World Federation of Occupational Therapists (W.F.O.T.) visited South Africa to investigate the state of the profession under apartheid. They found *“an active but competent group who need to develop strategies for better use of the potential political power they possess ... Few signs of discrimination by occupational therapists were found although they are working in a system that still condones apartheid. It became increasingly clear that in spite of the political climate, South African occupational therapists ascribe to the same philosophy as their colleagues in other countries...”*¹⁴ (Claxton, 1998) The delegates saw white South African occupational therapists acting with care and client-centred competency in meeting the impairment needs of their patients but being apathetic in their political activism and ethical awareness of the impact of injustice on the social health and human dignity of their Black clients.

These findings correlate strongly with the themes that have emerged 10 years later from the Truth and Reconciliation Health Sector Hearings.¹⁵ These hearings give a striking account of how an entire health bureaucracy could be based on racism and how the culture of apartheid could result in human rights violations through erosion of the ethical accountability of health professionals.

Occupational therapy codes of conduct and ethics have traditionally developed as rules supplementary to law and typically specify “what to do” and “how to behave” in clinical encounters with individuals or groups of clients.¹⁶ These codes guide the resolution of ethical dilemmas that arise within a disease paradigm or between individual practitioners and the public or colleagues.

Chapman and Rubenstein (1998) suggest *“When health concerns are limited to the objective of curing the disease and healing impairment, the likelihood increases that health professionals will not relate in a holistic manner to issues relating to the human worth and dignity of their patients. Such moral disengagement may be a critical factor in abusive behaviour.”*¹⁵ This raises questions about the traditional methods of occupational therapy practice and ethics education. The teaching of ethics in South Africa usually occurs by what has been called a *“rules, roles and osmosis approach”*¹⁶ which renders many moral questions invisible to moral debate. A lot of time has been spent on perfecting technical expertise for the alleviation of impairment, and very little time has been spent on developing population reasoning and practice and on expanding ethical and moral reasoning to include a social justice and equity perspective. This could account for our political apathy during apartheid and unless addressed, could lead to the marginalisation of occupational therapy as a non-essential public healthcare service in the future.

Baldwin and de Gruchy (1998) summarise the themes from the Truth and Reconciliation Health Sector Hearings as follows:

- ◆ *“Apartheid permeated the entire health sector, distorting and corrupting health professional training, research and service delivery. Social and political agendas rather than the needs of patients determined practice priorities thereby violating the human rights of the majority of South Africa’s population.*
- ◆ *Abuses occurred along a spectrum of settings from custodial care to the banal day to day functioning in segregated health facilities. Most violations of human rights in health took place in the grey zones by ordinary people doing their jobs within a system that hid its flaws beneath a veneer of professionalism.*
- ◆ *Organisations and professional institutions failed to recognise the non-neutrality of race-based health practice, scientific research, training and even codes of ethics.*
- ◆ *Scapegoating a few “bad apples” as extremists was far easier than overhauling an entire system. Instead of radically confronting the context that enabled immoral and unethical professional behaviour to flourish, we either excused the aberrations of individuals in a limited discourse of “right” and “wrong”, or we excused individuals because of ignorance and apathy.*
- ◆ *There has been a lack of support for individuals and organisations that resisted oppression.*¹⁷

(The profession has yet to acknowledge those occupational therapists in South Africa and abroad who worked behind the scenes to take a political stand on behalf of the oppressed.)

I think that the value of these hearings has been their trajectory – they spearheaded a process of self-reflection that has galvanised health professionals and health institutions to take stock of their individual and corporate responsibility in the face of racism and all forms of oppression and discrimination. A quote from a response by a white physiotherapist to the Health Sector Hearings in June 1997 reads as follows:

*“It was not difficult to notice the gross human rights violations and inequalities caused by the apartheid policies. I think for us to excuse ourselves as unknowing, innocent participants is dishonest. I think it would be more accurate to apologise for the apathy, the passive way we accepted apartheid by not challenging the status quo in the hospitals where we worked every day. Being white and sheltered is no excuse. We did not have blinkers and are not people who cannot think. I feel that integrity calls for us to apologise, admit to our blindness and acknowledge the sins of omission. We were wrong and we can learn from that.”*¹⁸

I endorse this submission as well as the one made by the Occupational Therapy Association of South Africa. I know that we worked hard and well to treat patients of all races to the best of our ability often under appalling conditions. What has worried me the most is my capacity for moral disengagement through apathy, inaction and silence, this despite my professional socialisation into the highest ideals of occupational therapy. I missed the mark of virtuous professional behaviour then. What am I missing now in a rapidly changing health scenario where contemporary health issues continually confound us with regards to their ethical and human rights implications?

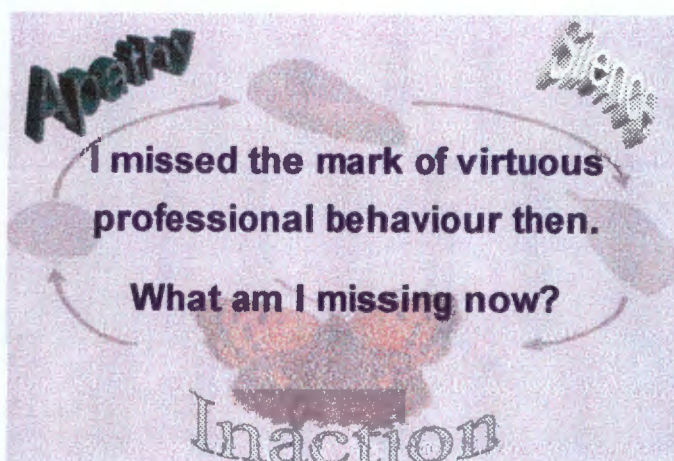


Figure 6 – Personal Challenge

A contemporary reorientation within ethics will align South Africa occupational therapy with the recommendations from the Truth and Reconciliation Health Sector Hearings which suggest amongst others:

- ◆ Elimination of racial discrimination and disparities
- ◆ Adoption of human rights standards for health professionals
- ◆ Incorporation of human rights education and cross-cultural understanding in professional training. ¹⁵

Internationally the need for a simple, shared code of ethics to guide all who influence and deliver health care has been recognised. Separate moral frameworks in which each discipline seeks to gain its own moral high ground is seen to fail because they do not *"recognise explicitly enough that they affect the well-being of patients less as separate elements than together as a system of interdependencies."* ¹⁹

The Tavistock Group (1999), comprising physicians, nurses, healthcare executives, academicians, ethicists, a jurist, an economist and a philosopher from four different nations (including South Africa), presented its latest working draft of five major ethical principles which it believes should govern health care systems. ¹⁹

- *Health care is a fundamental human right.* If adopted, it means that South Africans have a right to occupational therapy services and the profession has a right to lobby for the recognition of its role as an essential healthcare provider.
- *Even though the care individual is at the centre of health care delivery, this must be viewed and practiced within the overall context of working towards the greatest possible health gains for groups and populations.* If adopted it means that occupational therapy must adapt its ideology and methodology to accommodate populations.
- *Health care systems are responsible for preventing illness and alleviating disability.* This implies the need for occupational therapy to orientate its paradigms towards public health systems, for example, health promotion. It will need to orientate its methods towards advocacy and accommodation and equalisation of opportunities for disabled persons.
- *Co-operation between all those working within health care systems is imperative, both for the individual patient and for the population as a whole.* Occupational therapists should not be threatened by role blurring and role sharing as we enter the era of multi-skilling and generic services. The overwhelming need out there creates a space for all of us to work towards the building of a healthy nation.
- *The authors cite the improvement of quality as being at the heart of health care systems.* Occupational therapists will have to take outcomes based practice and quality assurance seriously. Our uniqueness will increasingly be defined by the kind of health outcomes that result when people participate in the occupational therapy process.

The Tavistock principles will not override the Georgetown principles. Both sets of ethical principles will be necessary for health professionals to make reciprocal transitions between client-centred and population-centred practice. I think these transitions are very difficult for occupational therapists. We are professionally socialised to practice predominantly within a care moral orientation and have yet to develop explanations for the role and scope of the profession in public and community health within a justice moral orientation. For example, the realities of poverty, violence and resource limitations in South Africa will continue to restrain our ability to provide all the occupational therapy services we think are needed.

This is an ethical dilemma that requires an accurate analysis of social health care values and the ability to balance moral duty and the consequences of our decisions. Foto (1998), addressing financial constraints and ethical dilemmas, suggests that *"Cost containment may mean fewer but not necessarily inferior services. If appropriate, equitable allocation of health care resources is valued then we should move towards the value of only offering services to those persons who will benefit from them."*⁸ She suggests that the potential worth and value of the outcomes of occupational therapy rather than the presence of impairment or disability should determine the locus and nature of service. I suggest that we are, at this stage, insufficiently aware of the impact

that ethics has on our professional identity and our ability to judge the quality and relevance of our work.

The narrow definition of health as the absence of impairment has to be juxtaposed with the broader definition of health inclusive of social justice, human rights and equity. To do this requires both a care and a justice moral orientation.²⁰

Moral Orientation

	<u>Care/Response Moral Orientation</u>	<u>Justice/Rights Moral Orientation</u>
View of Relationship	Attachment / Detachment	Equality / Inequality
View of Vulnerability	Connectedness / Abandonment	Fairness, Rights / Oppression
Ethical Dilemma	Threat to the Relationship (Subjective)	Threat if done to anyone (Objective)

(Gilligan, 1982)

Table 2 –Moral Orientation Framework (adapted from Gilligan 1982)

A care orientation is concerned with the complexities of sustained attachments, compassion, forgiveness and close personal relationships. Within a care perspective, morality requires not hurting others, condemning all violence, and exploitation and nurturing relationships and connections between people. A care orientation is attributed to predominantly females and connects vulnerability with the moral issues of support vs. abandonment.²⁰

A justice orientation is concerned with whether one will be oppressed or treated fairly. It is attributed predominantly to males and focuses morality on issues of individual, and ultimately societal rights. It supports adherence to standards and universal ethical principles of justice, autonomy, reciprocity, equality and respect for all human beings.²⁰

A contemporary interpretation of ethics seeks to promote the ethical and moral reasoning of health practitioners by developing both moral orientations and by conscientising them to all forms oppression, even under the guise of caring.^{21 22 23 24}

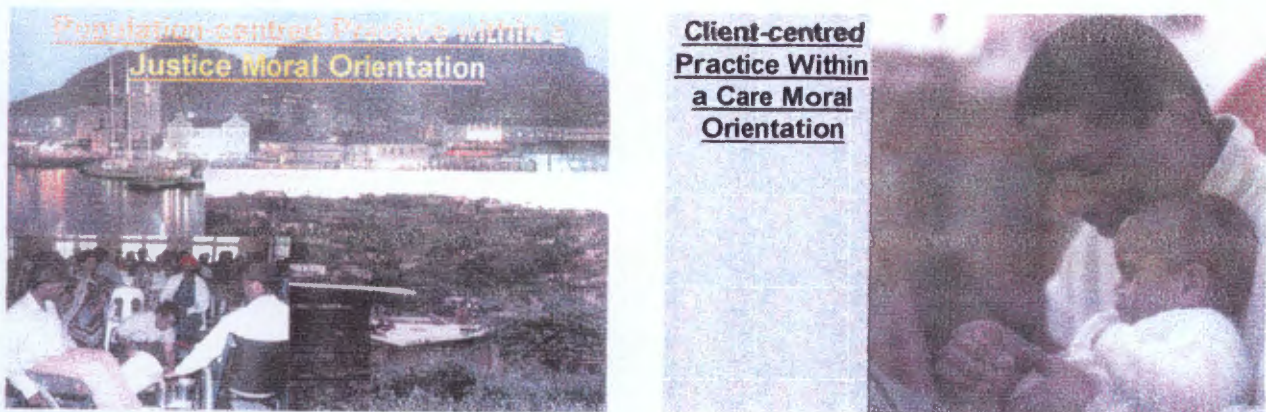


Figure 7 – Domains of Practice

Occupational therapy socialisation in the dominant paradigm has been mainly towards client-centred practice within a care moral orientation. Very limited professional socialisation towards population-centred practice within a justice moral orientation has occurred to date. Practice in a developing country requires occupational therapists to embrace both moral orientations and concomitant practice domains, that is individual client care as well as service systems aimed at the development of a healthy nation. Embracing the values of social justice, equity and human rights will necessitate the alignment of professional ideologies and technologies with models of public health such as community development through the empowerment of disabled persons.^{25 26} The necessity of these transitions has been precipitated by the major period of crisis within which the profession has found itself over the past decade.

A Period of Professional Crisis

South Africans have justifiably earned international admiration for their peaceful transition to democracy. Our constitution is widely regarded as being amongst the most progressive in the world with the Bill of Rights (Chapter Two), getting particular praise from the Western liberal democracies. I briefly quote from the epilogue to the South African constitution:

"The adoption of this Constitution lays the secure foundation for the people of South Africa to transcend the divisions and strife of the past, which generated gross violations of human rights, the transgression of humanitarian principles in violent conflicts and a legacy of hatred, fear, guilt and revenge. These can now be addressed on the basis that there is a need for understanding but not for vengeance, a need for reparation, but not for retaliation, a need for ubuntu but not for victimisation ... with this Constitution, we, the people of South Africa open a new chapter in the history of our country."

It has also opened a new chapter in the history of occupational therapy in this country. Within this period of professional crisis, occupational therapy is certainly going through developmental change. For example:

- ◆ The adoption of the primary health care approach has begun to dismantle established models of health care. The district health system means we can facilitate the occupational adaptation of our clients within their familiar, home and work environments.
- ◆ Health systems and community developers value our professional perspectives on health and human occupation. There is a growing appreciation of perspectives on wellness, quality of life and client autonomy that have historically been part of occupational therapy beliefs and values.
- ◆ Occupational therapists can work in partnership with disabled persons towards attainable goals due to the backing of progressive legislation and liberating policies that chart a course for the creation of an equitable, accessible and progressive health service. Disability is officially viewed as a human rights and development concern that cuts across the responsibilities of a wide range of government departments and civic institutions paving the way for occupational therapists beyond the traditional health sector domain of practice.

Reality is however far removed from the ideals of a progressive constitution. Dr. Brundtland, Director General of the World Health Organisation, in a recent policy speech on health as a basic human right, predicted that violence and poverty would be two of the world's leading burdens of disease by 2010. Where there is violence and poverty there will be ill-health, poor development and poor human rights. Our country is in the grip of social anomie.

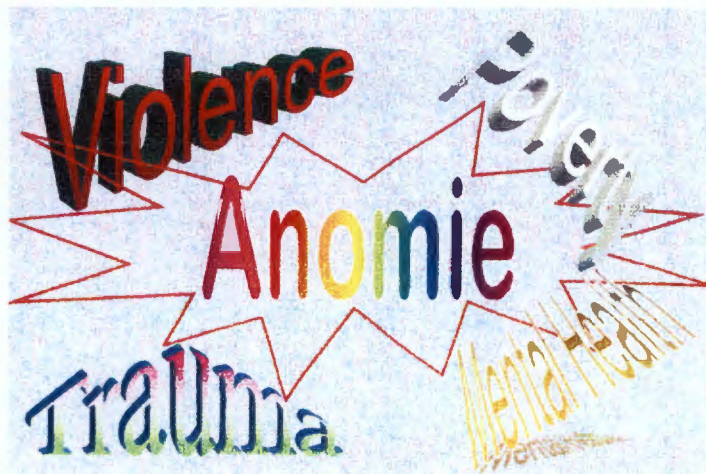


Figure 8 - Realities

Anomie is a disorder of society indicative of persons losing intimate, meaningful contact with their community and therefore the loss of inner coherence, unity and purpose in life. Norms and values no longer control the behaviour of citizens and violence, corruption and lawlessness have become

a way of life for some and an expectancy of life for law-abiding others. A culture of volunteerism, service and commitment seems to have been replaced by one of demand, self-centredness and entitlement. Maphai (1997), speaking on the consequences of liberation suggests *“The root of this response probably lies in the fact that the liberation struggle and the total onslaught ideologies delegitimised self interest. In response, once we gained our freedom, we came to indulge self-interest to the exclusion of social interest.”*²⁷

This social anomie makes it progressively more difficult for therapists to maintain their vision, enthusiasm and sometimes even those virtues that promote the ethos of occupational therapy. These problems are exacerbated by the widening economic gap between the “have’s” and the “have not’s”.

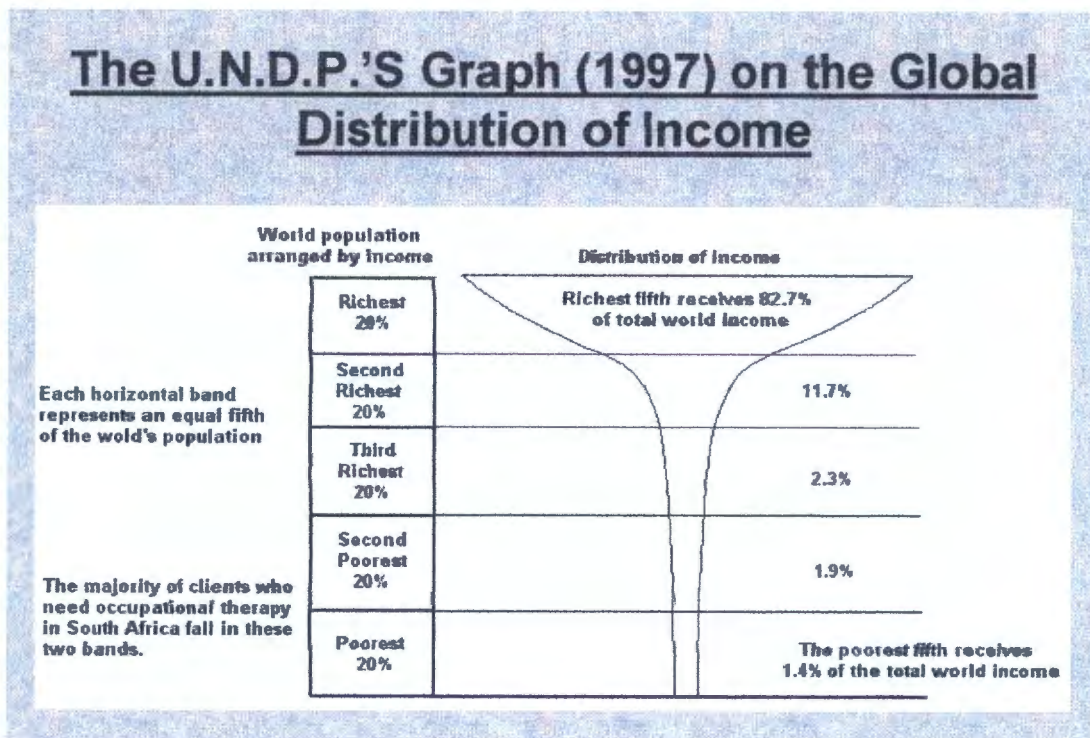


Figure 9 – U. N. D. P.'s Distribution of Income Graph

The U.N.D.P.'s graph (1997) on the global distribution of income captures a powerful expression of the situation in South Africa given the fact that South Africa is still regarded as the second most inequitable society in the world.²⁸ This graph offers a stark depiction of the challenges facing occupational therapy in a developing nation and which should contribute towards the definition of a new paradigm of occupational therapy in the country. By the late 1990s, the top fifth of the world's people, living in high-income countries had 82.7% of the world's gross domestic product; the bottom two fifths, just 3.3%. The majority of clients that need occupational therapy in South Africa fall in these bottom two bands. This should place poverty, equity and development firmly within the profession's social responsibility. The implications of this could be:

Implications of Occupational Therapy's Social Responsibility

- ◆ Professional models of practice, value systems and methodologies that are developed by our colleagues in affluent Western countries need to be redefined and adjusted to accommodate the realities of practice in Africa. We have to engage in an explicit process of reflection and debate on the philosophy of the profession and its application to the ideals of the African renaissance.
- ◆ The inequities between the users of private and public health sectors should become an agenda for professional debate and redress. Just under one fifth of South Africans belong to a medical aid scheme yet this group has access to 85% of pharmacists and 60% of medical professionals working in South Africa. More and more occupational therapists are entering private practice due, in part, to the severe reduction of posts in the public health sector. This trend will, on the one hand, strengthen the social power and political rewards of occupational therapy by raising the profile of the profession amongst those who can afford its services. On the other hand, the trend will seriously deplete the access of the majority of South Africans to the benefits of occupational therapy unless concerted effort is made to market the profession, expand its technologies and lobby for the creation of trans-sectoral posts. Opportunities exist for the expansion of occupational therapy in diverse sectors such as welfare, industry and agriculture. For example, the Skills Development Bill, Labour Relations Act and the Employment Equity Act pave the way for occupational therapy at the interface between disabled persons and employment. We have to take risks in crossing the health sector divide. This means a re-orientation of our knowledge base. Consultancy, human resource training, organisational development, business management and entrepreneurship, and consumer advocacy should, to name a few, become important curriculum agendas in occupational therapy.
- ◆ The survival and progress of the profession in a cash-strapped developing country is dependent on the profession's knowledge of health economics and its ability to prove the validity of its economic contribution. Confirming the cost benefits of occupational therapy services deserves to become a national research priority.
- ◆ The racial profile of occupational therapy practitioners should progressively reflect the demographic distribution within the country. This has been addressed in a previous Vona du Toit Memorial Lecture by Robin Joubert (1997),

I have tried to frame a snapshot of the period of professional crisis. It represents a much broader cultural transformation that includes the impact of the liberation struggle, politics of minority movements, transitions from medical care to self care, hierarchies to networking and north to south and east to west global developments to name a few. These and other social forces have precipitated the period of accepting a new professional paradigm.

The Period of Accepting a New Paradigm

I suggest that South African occupational therapy is in the balance and needs to negotiate its evolution into an African identity and a new professional paradigm through the transformation of its world view, methodologies and identity.

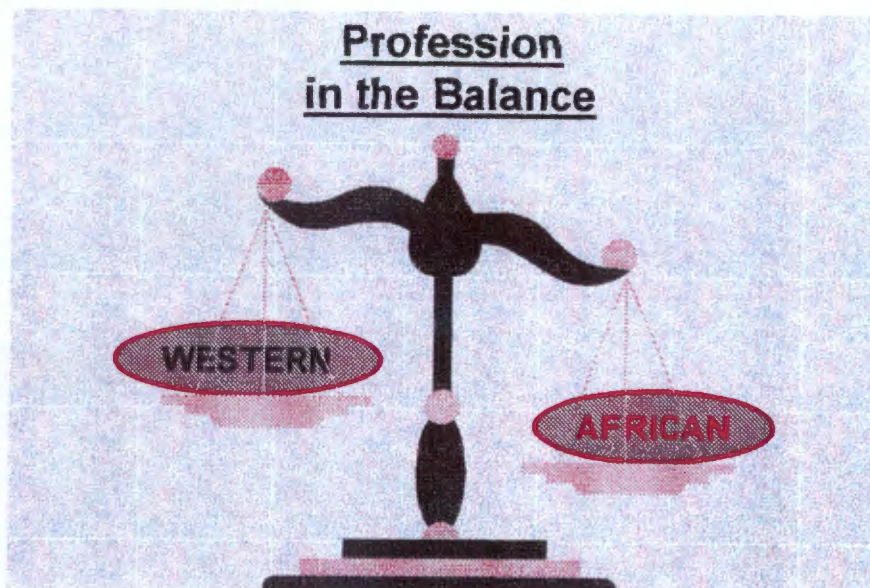


Figure 10 – Profession in the Balance

Transforming our Professional Worldview

Our almost exclusive allegiance to the biomedical model and traditional scientific paradigms in the past compromised our ability to listen to the needs and wants of our consumers and society. As a predominantly female and caring profession we have been disempowered by the hegemony inherent in the dominance of the medical model and by the pervasive social phenomenon of devaluing or excluding women's knowledge. To compete with medicine will be to fail. Our professional power lies in strengthening and articulating our canons of knowledge as these balance the reductionism of the Western and medical worldview.

To Westerners and men in particular, are attributed epistemologies that conceptualise the knower as fundamentally separated from the known and the "known" as an autonomous object that can be controlled through objective, impersonal, hand-brain manipulations and measures. The individual becomes the centre of the social space and there is little conceptualisation of the group as a whole. There is an implicit assumption that the white male experience is universal and representative of humanity and that it constitutes a basis for generalising about all beings.^{29 30} Canons of knowledge based on this worldview marginalise and silence other ways of thinking and knowing. Now is the time to embrace opportunities such as qualitative and action research

methodologies that enable us to give a voice to the tacit knowledge that occupational therapists have always had of the phenomenological dimensions of human experience.

In an African worldview, there is no gap between the self and phenomenal world. It embraces a 'man-to-person' rather than a 'man-to-object' understanding of reality. The process of coming-to-know affects the known and the self embraces a communal rather than an individualistic orientation. In African cultures, ubuntu serves as a moral-political philosophy that helps to entrench a collectivism in which all individuals are assumed to be linked in a web of inter-relatedness. Interdependency, common fate and social harmony take precedence over individual interests.^{30 31} Client-centred practice in this worldview must embrace the individual and the collective to which he, or she is inextricably linked.

We need to learn how to balance other worldviews beyond the Western paradigm. I suggest that we do this by broadening our knowledge base by building trans-disciplinary alliances with disciplines such as sociology, anthropology, theology and psychology that have already well established African epistemologies. The development of occupational science has been a politically expedient move on the part of the occupational therapy profession. It has articulated the difference between the culture of occupational therapy and other disciplines and has highlighted the potency of human occupation. Occupational science must continue to be an empowerment strategy within occupational therapy and a vehicle for enhancing the political rewards of the profession.³²

Transforming our Professional Methodologies

In an era of technical reductionism we minimised our unique professional perspectives on human capacity through the potency of human occupation and in the process acquired a technical status. Occupational therapy has the unique ability to foster optimal occupational performance, meaning and purpose in life. We need to recapitalise on the strength of our holistic view of humans and move beyond a delimiting sense of practice. Critical thinking skills and reflection expand our horizons and enable a holistic analysis of the biopsychosocial and occupational needs of individuals and large groups.³³ This, together with our ability to work in partnerships with people in adapting their occupational contexts to meet their health needs, makes us well equipped to act as health programme consultants and capacity developers with diverse populations of people in diverse contexts.

Optimal Occupational Performance



Figure 11 – Optimal Occupational Performance

The over-reliance on the medical model and on technical skill should therefore be challenged through an ideological shift from the medicalisation of disability to a social constructionist view in which professionals collaborate with, rather than do things for, disabled persons.



Figure 12 – Medical Model vs. Social Model of Practice

Time, energy and money should no longer be funneled exclusively into the treatment of one small part of the total problem; a part that may be insignificant in comparison to the complexities that are more difficult to understand but have a profound impact on the life situation of the person being

served.³³ Occupational therapists can acquire, interpret, adapt and disseminate knowledge about biopsychosocial aspects of health and facilitate links between human occupation, wellness and quality of life through matching the capacity of people with the demands of their environment. Our unique way of thinking is our most marketable asset and should become a trademark methodology in both client-centred and population-centred practice.

Transforming our Professional Identity

I think occupational therapists in Africa need to recognise themselves as both health professionals and as intellectuals.³⁴

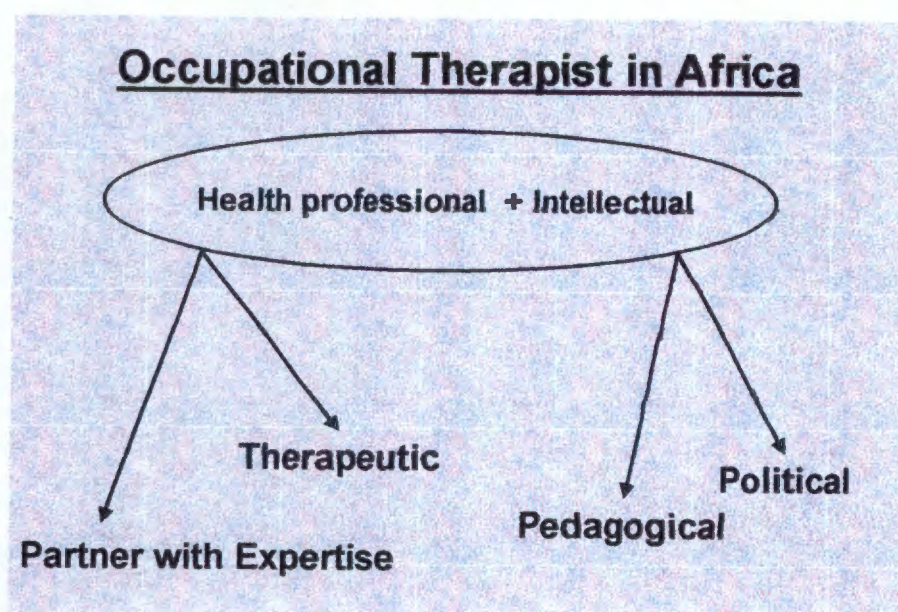


Figure 13 – Expanding Professional Identity

Our identity as health professionals ought to include being therapist and partner with expertise. This identity requires the therapist to juxtapose reductionism with phenomenology, that is, address impairment or health needs through the client's personal narrative rather than through prescriptive therapeutic strategies.

As intellectuals we aim to mediate, legitimate, advocate and produce ideas and social practices pertaining to people's health through human occupation; for example, to demonstrate solidarity in opposing social and fiscal policies that compromise the interests of vulnerable and at-risk populations. This identity is essentially pedagogical in function and potentially political in nature.³⁴ Society judges occupational therapists by the outcomes of our therapeutic activities and sociopolitical behaviours. Our bit in the calabash should be visible in the changed, productive lives and in making a contribution to the conscientisation of society.

Our Bit in the Calabash of a New Society

In summary I present a conceptual heuristic framework that may begin to define our African identity. It juxtaposes some of the profession's philosophical-ethical dimensions that have addressed in this lecture and that I believe need to be negotiated if we are serious about transformation.

<u>In an African Occupational Therapy Identity</u>	
<u>We Value:-</u>	
Both	And
dignity and worth of the individual	dignity and worth of the collective
participation in occupation	participation in communal occupation
self determinism, freedom, independence	interdependence, co-determination
latent capacity of the individual	latent capacity of the collective
human uniqueness	human diversity
mutual co-operation	Ubuntu
<i>Kielhofner, (1985), A.O.T.A, (1987), Palatajko, (1996)</i>	

Table 3 – Suggested African Occupational Therapy Values

I developed this framework by contrasting the occupational therapy values articulated by our American and Canadian colleagues with values that might reflect something of what it means to be an African occupational therapist working amongst and alongside the peoples of Africa. ^{12 35 36}

In an African Occupational Therapy Identity

Our Beliefs and Practices are:

Both	And
Western objectivist	African constructionist
Individual, client centred	Group, population centred
Hospicentric/unisectoral	Communicentric/multisectoral
Narrow definition of health	Broad definition of health
Activity centred	Human occupation centred
Medical model	Social model
Mind/body dualism	Phenomenological

Table 4 – Suggested African Occupational Therapy Beliefs and Practices

In this framework I juxtapose the professional beliefs and practice domains, which indicate the broadening role and scope of occupational therapy in response to our African heritage.

In an African Occupational Therapy Identity

Our Ethics are:

Both	And
Traditional	Contemporary
Care moral orientation	Justice moral orientation

Table 5 – Suggested African Occupational Therapy Ethics

This framework captures the need for a resuscitation and revision of ethics and human rights in South African occupational therapy practice and education.

Captured in these three frameworks are a few pointers for transformation into an African occupational therapy identity, which I hope, will fuel much debate and professional reflection. It portrays some of the paradoxes in beliefs, values and methods that have to be negotiated if the profession is to accept a new paradigm in order to flourish in the African context.

But what if our choices are forced? Which way do we go, and what are the consequences?

Is there an ethical obligation here, comparable to that facing us in the apartheid era?

How prepared is the occupational therapy profession in South Africa to make this choice in terms of:

- ◆ Understanding the implications of the contrasting parameters of practice?
- ◆ Capacity to deliver on an emerging new paradigm?
- ◆ Setting structures in place to realise the vision?
- ◆ Politicising its agenda in the interests of our clients?

I challenge all of us individually and collectively to reflect on these questions. We cannot let this critical opportunity for the profession's development go by without rising to the challenge. Let's not repeat the mistakes of the past. Let's demonstrate that we have learnt from our history and are willing to build a new future.

I want to suggest some strategies that may enhance the process of transformation and facilitate the transition through Kuhn's (1970) cycle of professional development.

Transformation Strategies

- ◆ Stop rearranging our house within the medical model.
- ◆ Nurture and guide the growth of ethics.
- ◆ Become a critical thinker and reflective practitioner.
- ◆ Take self-development seriously.
- ◆ Become a research consumer and contributor.
- ◆ Support OTASA transformation initiatives.
- ◆ Affirm diversity in curriculum.
- ◆ Market and live out the ethos of the profession.




Figure 14 – Transformation Strategies

1. **Stop rearranging our house within the medical model.**
 Broaden the definition of health as inclusive of social justice and equity. Develop and document the role and scope of occupational therapy in public and community health. Take health promotion seriously and re-orientate practice to socio-political realities. Challenge the hegemony of medical hierarchy.
2. **Nurture and guide the growth of ethics.**
 Strengthen professional oaths to reflect a deep sensitivity to human rights. Read the Truth and Reconciliation Health Sector Hearings Report and debate its recommendations. Advance ethical and moral reasoning through ethics discussion groups. Tap into moral and ethical development and human rights literature.
3. **Become a critical thinker and reflective practitioner.**
 Move beyond the reproduction of accumulated knowledge and clinical expertise to reflective examination, interpretation and understanding of available evidence. Develop clinical reasoning and population reasoning skills.
4. **Take self-development seriously.**
 Pursue post-graduate qualifications. Challenge your assumptions, beliefs, prejudices and take risks in engaging in anti-bias training and the possibilities of lifelong learning.
5. **Become a research consumer and contributor.**
 Keep up to date with literature in your field and embark on research that validates the premises of occupational therapy beliefs about the links between human occupation and health. Eliminate race as a criterion in health research. Develop transdisciplinary research allies.
6. **Support OTASA transformation initiatives.**
 Establish a political action sub-committee in OTASA to guide the profession in understanding and responding to the nature and actions of government and other important political issues. Appoint an ombudsman to hold the professional board accountable for monitoring the human rights culture of occupational therapy in South Africa. Support action within the profession to learn from our apartheid past. We have to do more than issue a generic apology before we can claim to be playing a fundamental role in furthering human rights in South African healthcare.
7. **Affirm diversity in curriculum.**
 Develop advocacy skills to empower at risk and vulnerable groups without resorting to paternalism. Dismantle and deconstruct the legacy of racial and male domination in canons of knowledge. Include the perspectives of those who have traditionally been excluded. Build partnerships with disabled persons and claim disability as a human rights issue.

8. **Market and live out the ethos of the profession.**

Frame the social worth of the profession in constructs that are familiar to and valued within a collectivist culture, for example, there is no word or concept for “rehabilitation” in Xhosa.

Face anomie by making an inner choice not to be dependent on outer conditions but on the will to claim your freedom of choice whatever the circumstances.

I want to encourage all of us to do our Bit in the Calabash by sharing a quote from Nelson Mandela’s book, Long Walk to Freedom.

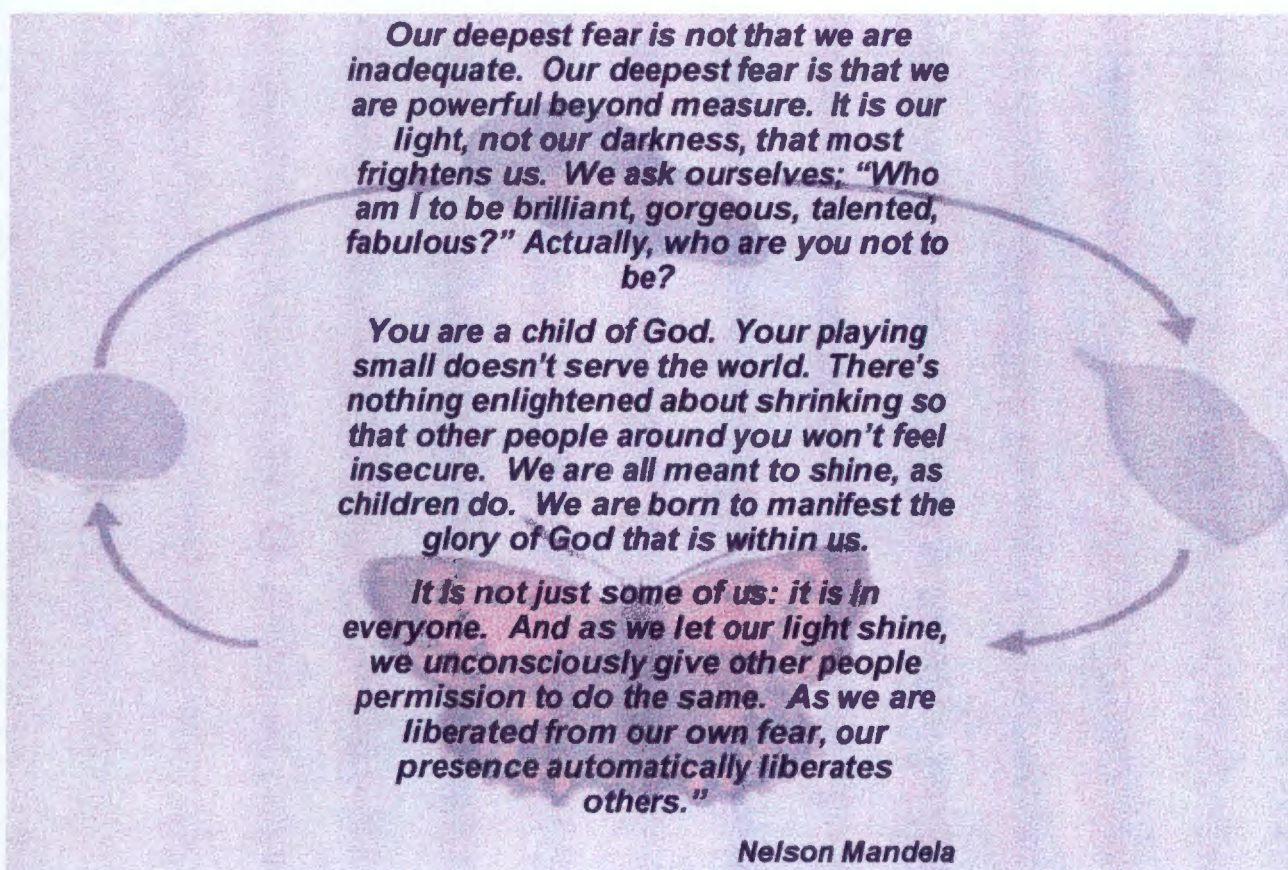


Figure 15 – Quote from Long Walk to Freedom

Conclusion

There are no instant metamorphoses, quick fixes or smooth, painless transitions. It is hard to put aside theoretical and ideological beliefs that have for years been the basis of our actions, explanations and hopes. We need to take risks in the deliberate reconstruction of our ways of knowing, being and doing but need to do so wisely, knowing that impatience and unrealistic expectations lead to burnout, change fatigue and despair. We have to take the long view; work towards attainable goals based on realistic assessments of what is possible.

Reflecting on Vona's influence on my career I was reminded of T. S. Elliot's Choruses from the Rock.

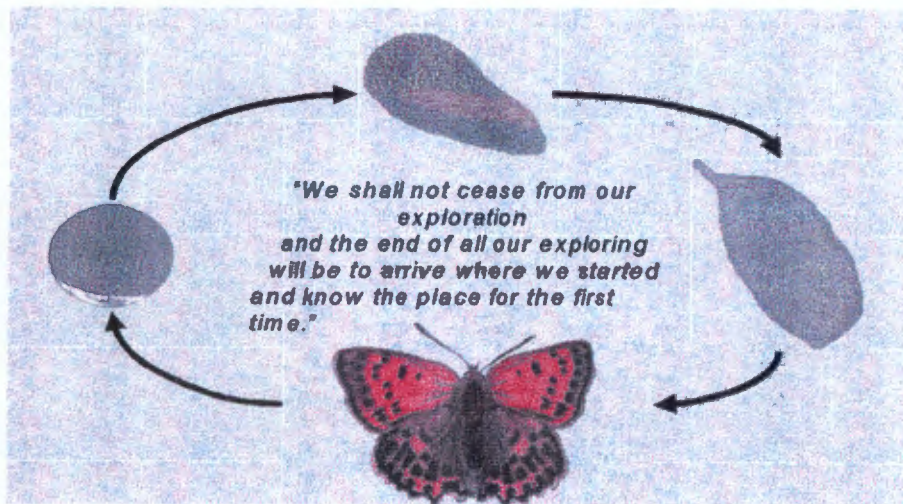


Figure 16 – Quote from T. S. Elliot's Choruses from the Rock

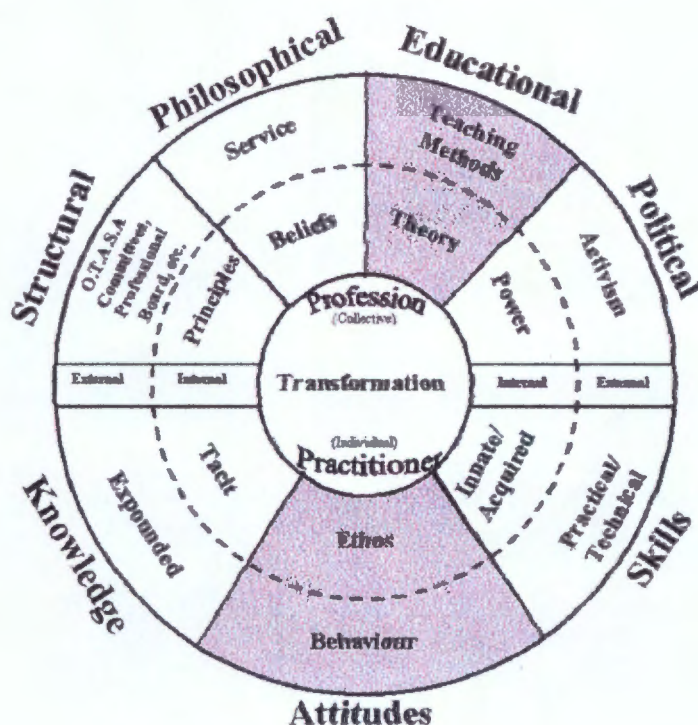
I have, in preparing for this lecture, arrived where I started 26 years ago and in a sense am only just beginning to know the place for the first time; a place where the Thou is no longer only singular as it was back then but also collective; a place where occupational therapists build affirming I:thou relationships not only with individuals but also with communities; a place where occupational therapy pours its beliefs and values into client-centred practice and into creating a just and caring South Africa society.

Thank You.

Epilogue

Introduction

How may we move beyond rhetoric to transformative action? I suggested at the outset of this dissertation that collective professional transformation is a process that must begin with shifts in the moral values, attitudes and beliefs of individual practitioners. This is also the central theme of the memorial lecture that challenged individual occupational therapists and the profession collectively to consider the impact that a renewed awareness of human rights and ethics would have on their professional beliefs, knowledge, methods, practice and identity



I indicated that the dissertation would focus on only two of the dimensions of transformation addressed in the memorial lecture and that the epilogue would discuss educational strategies aimed at the attitudinal development of undergraduate occupational therapy students.

The aim of this epilogue is to describe the educational theory and teaching methods used in the UCT occupational therapy department to promote the attitudinal development of undergraduate occupational therapy students. Attitudinal change is considered to be pivotal in professional socialisation and in developing professionalism, in that it lays the foundation for enhanced ethical and moral reasoning.

Background

I suggested in the memorial lecture that strategies such as the nurture and growth of ethics, critical thinking, reflective practice and the affirmation of diversity in curriculum, may contribute to developing practitioners with changed knowledge, skills and attitudes and therefore, ultimately, a transforming profession. I indicated that the myriad changes in a developing country would require a revisioning of occupational therapy education in order to produce the kind of therapists that the country and the African region needs. Slattery (1995) suggests *"there are no absolute principles to guide the education process; simply pivotal ideas in the schema of an approach to education that may contribute to a transformation of learners."*

The pivotal ideas and practical ways in which the occupational therapy department at the University of Cape Town (UCT) aims to transform its learners, is vested in an explicit commitment to the affirmation of diversity. The department is committed to raising awareness about diversity and trying to address all issues that lead to discrimination. *"We believe that our attitude to any human condition that is different from what we ourselves are familiar with, is usually based on assumptions, stereotypes, prejudice and personal values and that it is our professional responsibility as staff and students to explore and deal with these biases on a personal and organisational level. We aim to unlearn prejudice, foster awareness of human rights and celebrate diversity by explicitly using strategies that address discrimination in constructive and creative ways."* (Personal communication to the students and staff by the head of department, Professor R. Watson, 1999) Some of the dimensions of diversity about which we raise awareness are:

- ◆ Language: what language is preferred, with whom, when?
- ◆ Culture: what are the assumptions and prejudices we have internalised and do these lead to the oppression of others?
- ◆ Educational preparedness: does personal educational history make a difference to the way people learn?
- ◆ Racism, ageism, disabilism, sexism and gender, class and religious bias: what impact do our attitudes and stereotypes have on the balance of power in relationships between people?

We recognise a parallel between the philosophy of occupational therapy and the educational tasks inherent in the stated aims. Occupational therapists value and acknowledge autonomy, individual difference and human complexity in our client population. The systematic exploration of these dimensions in our student population by our students themselves, is seen to be an important vehicle for experiential learning and professional socialisation. The ethos of the department is fostered in such a way as to give students a lived experience of occupational therapy philosophy and of those values, beliefs and attitudes that anchor the professional in daily practice. It is through language, dialogue, conversation, debate and narrative, and in action, that values,

attitudes and beliefs are constructed, manifested, changed and enacted (Joubert, 1992). The eventual attitudinal and moral maturation of the student over a four year undergraduate programme is seen to lay the foundation for a deeper appreciation of professional ethics and codes of conduct.

Attitude adjustment as a result of altered awareness is a process by which the normative orientations pressed upon the individual during professional socialisation becomes part of the individual's motivation and disposition to conform. The richness of shared experience and group processes are explicitly used to foster intra- and inter-personal learning.

- ◆ Diversity is seen as a group resource
- ◆ Vigilance about what is (and is not) said and done, is encouraged
- ◆ Awareness of human rights is awakened and challenging dominant worldviews that may perpetuate oppression encouraged.

Theoretical Rationale: The Living Curriculum as Transformation Strategy

The foundations of adult education prevent the vision from becoming contrived. *"Affirming diversity does not mean tolerance, acceptance, patronisation, benevolence or compassion for these come from a place of implied superiority or favours granted to individuals who are not part of the norm but who deserve some special treatment ... the moral imperative grounded in the ethical and humanistic approach and devoted to the restoration and advancement of human dignity and respect, is at the core of affirming diversity."* (Goduka, 1996: 30, 31) To realise these injunctions, we have built the transformation process on a well-established adult education philosophy that emphasises the autonomy of students in acts of learning and taps personal experience as a learning resource. (Weil and Mc Gill, 1992; Brookfield, 1995)

We believe adult education entails more than grasping knowledge. *It involves actively transforming knowledge and being transformed by it through the praxis of engagement between educators, learners and learning systems (for example, contexts, texts, people) in a process of exploration, action and reflection. Praxis nurtures the development of self directed, empowered life long learners who recognise that single answers to problems do not exist and that knowledge is relative and provisional. Our educational expectation is to move students beyond memorisation and the reproduction of accumulated knowledge to critical examination, interpretation and understanding of available evidence. Slattery (1995) captures something of our orientation to curriculum. "generations of educators have been schooled to believe that the curriculum is a tangible object, the lesson plans we implement, or the course guides we follow rather the process of running the racecourse."* (p 56)

The dynamic product of this 'racecourse' usually bears the stamp of its originators, thereby lending a particular ethos to the academic and social tone of the department and somewhat distinctive characteristics to its graduates. A living curriculum is dynamic in its responsiveness to developments in the knowledge base of the profession without being over-inclusive and in its responsiveness to socio-contextual demands without compromising the freedom of choice of runners. *"Students learn that diversity is real, normative and a valued fact of daily life in the classroom and that diversity penetrates the inner core of the teaching and learning process."* (Goduka, 1996: 32)

A living curriculum values the interdependence of teamwork whilst simultaneously fostering independent thought, confidence in expressing this and a positive self/professional image. Learning is understood (from the outset when students enter the programme) to be social and interactive. The variations in prior and continuous experience are drawn on, as resources that can systematically facilitate the construction of knowledge, the deconstruction of counterproductive attitudes and the reconstruction of behaviour patterns that demonstrate professionalism. Central to this is a personal experience for each student of the dialectical research process described in the introduction to this dissertation. Individuals may enter the 'research' cycle at any point, depending on their unique dispositions and learning needs. Research is here interpreted as the educational benefits of human inquiry, in a living curriculum.

The outcomes of this 'racecourse' or living curriculum should be the development of independent, critical thinkers with a strong sense of personal power, as proactive, initiating individuals engaged in continuous re-creation of their work worlds and social circumstances (Brookfield, 1991). Occupational therapy graduates should be attentive, and responsive to contexts in which their ideas and actions are generated; aware of their own and other's thought and action assumptions and open to alternative ways of looking at, and behaving, in their complex world.

All of this necessitates adult education strategies that are interdisciplinary, inclusive, eclectic and kaleidoscopic (Slattery, 1995) and consistent with the wide range of students' learning styles within various cultural, ethnic, religious and other social groups. A transformation approach to curriculum addresses content integration, the knowledge construction process and an equity pedagogy (Banks, 1990). The pool of teaching examples is explicitly pluralistic and diverse, so that concepts are drawn from the experiences and perspectives of all students; no one culture, gender or social class dominates the curriculum (Goduka, 1996). This author identifies four levels of inclusiveness in the curriculum, in the following diagram.

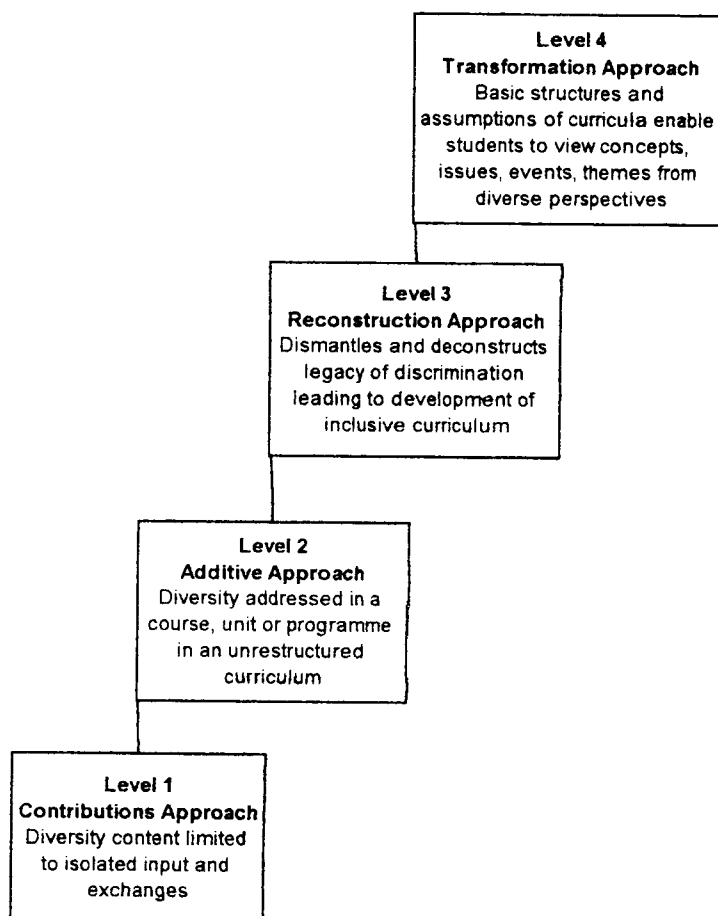


Figure 17 - Levels of inclusiveness in the curriculum (Goduka, 1996)

This progression towards a transformative curriculum captures something of what the UCT occupational therapy department aims to accomplish through journaling, median groups (Lyndon, 1995), class constitutions and a contemporary approach to ethics education.

1. **Journaling for reflective learning**

The promotion of reflection as a means of extending learning can be traced back to writings by Dewey (1933). The literature on reflective learning is exhaustive and will not be addressed here. (Atkins et al, 1993) Suffice to confirm that reflection is seen as a process through which new understanding and appreciations may be acquired, problems reframed and knowledge creation capacities developed. Reflective introspection raises tacit or hidden knowledge so that the complex epistemology of 'lived experience' may be uncovered. (Schön, 1983, Mezirow, 1991)

First year occupational therapy students are extensively orientated to the educational philosophy of the department. This orientation alerts them to 'think about their thinking' (Schön, 1983). The validity of their personal experiences is stressed, as is the relevance

of collegial learning. Facilitatory dyadic and group exercises (drama, art, music, etc.) act as catalysts for warming students up to share opinions with confidence.

They do an interpersonal skills development course that covers a wide range of topics specific to the development of the 'self' as primary therapeutic agent. Much time is spent on exploring attitudes, values and personal beliefs. One morning a week students also do fieldwork in diverse contexts followed by small group tutorials in which the praxis between theory and practice is unpacked, anxiety is contained and their intra- and inter-personal development explored. Students enter the dialectical cycle iteratively and are expected to journal their reflections on the inter-personal skills lectures and their fieldwork experiences. The requirements for deep reflection are made explicit. Students are encouraged to use poetry, art, etc. to enhance their imagination and give metaphorical expression to their thinking. The inter-personal skills course and their fieldwork experiences introduce opportunities for the explicit exploration of discrimination, bias, prejudice, human rights, personal values, morality and ethics. For example, over a series of the inter-personal lectures the lecturer noticed that black students were always the last to be included into small group exercises and therefore, invariably ended up in a group on their own. The dynamics of this phenomenon became the focus of much heated discussion and extensive reflective journaling. This approach to inclusivity requires educators to be very active in highlighting attitudinal challenges as well as extremely sensitive to their own biases and the responsibility of inclusive role modelling. This aspect of staff development is addressed at another level in the department and will not be covered here.

Journaling becomes a way of academic life for occupational therapy students throughout their four-year programme. It is a valued educational activity because it is evaluated, and becomes linked in third and fourth year, to the development of clinical reasoning and critical thinking. Students are encouraged to reflect on the contexts in which they work and to highlight issues of professional/ethical concern. The two processes of clinical reasoning and reflection are distinctly different yet complimentary and are used extensively by the department in formative and summative education (documented by colleagues Buchanan, Moore and Van Niekerk, 1998). Evaluations of journals yield ample evidence of perspective transformation over time. Students express appreciation for the role journaling has played in their personal and professional development over time. The impact of this on conscientisation and professional activism in response to human rights and ethical violations, can only be surmised at this stage.

2. **Median Groups**

Median groups exist in most forms of human social arrangement and provide the contexts for learning how to dialogue in creative and generative rather than conformist ways (Lyndon, 1995). Typically median groups consist of 15 – 35 people who formally meet for social learning through an exploration of relationships and preoccupation with the internal events of groups' discourse and behaviour. They provide opportunities for participants to explore their development from individual to social beings through an analysis of the conflict between the two, i.e. the interface between the internal and external world. *"The key point of transformation in the median group is the gradual emergence through dialogue of a culture of fellowship to which we have given the Greek term Koinonia ... it is a dual vantage point which allows us to draw together the need for personal definition and the transformation of our cultural context"* (Ibid, p 258). Literature in the field of group analysis is extensive and will not be addressed here. It may be noted, however, that convenors of median groups in the occupational therapy department are experienced group facilitators (not members of staff) who receive supervision and continuing education through membership of the local group-analytic interest group.

The goal is for occupational therapy students in all four years to participate voluntarily in four one and a half hour group sessions run throughout the academic year. The 'space' created by these groups allow participants to experience the potency of large group behaviour and their own role in the emerging symbolism of monologue, dialogue and discourse. (Foulkes, 1948) First year students initially struggle with the conceptualisation of the analytic process and are guided sensitively over the years towards understanding 'large group thinking' and their own reactions to group participation. Their group work training culminates in fourth year in a week-long small group experiential workshop. They again journal their experiences. Entries over time show a developing conscientisation towards oppressive sociocultural phenomena. The longitudinal educational outcome of these groups has yet to be investigated.

3. **Class Constitutions**

A class constitution describes the kind of learning behaviours and objectives which a particular class/group of students, at a particular point in their academic development, wish to pursue in order to maximise the learning potential of the education system in which they find themselves. Learners and educators craft a class constitution at the beginning of each academic year through democratic process. The evidence of everyone's voice is encouraged. It aims to alert participants throughout the year to perceptions about contexts that either contribute to, or impede their personal transformation. Constitutions explicitly address prejudice, bias and human rights in class-

specific terminology and act as a barometer by which to live the values, attitudes and beliefs of the profession. Student groups are taken, for example, for a hike up Lion's Head prior to drafting their class constitution. This 'occupation' becomes a focal event for exploring how the class arrives at decisions, which voice dominates, what happens to minority opinion, etc., and sets the scene for informed development of a representative class constitution. (Appendix 3) The concept of experiential group learning is well documented in organisational development literature. Its role in education in the moral development of health professionals has still to be validated.

4. Ethics Course in Fourth Year

The ethics curriculum in the department commences in first year with an exploration of the ethical principles and rules that guide professional judgement in solving ethical dilemmas. While much has been written about the prescribed, common methods for arriving at ethical decisions, little has been written about the setting or framing of ethical issues based on the relationship between morality, group ethics and law. (Koniak, 1996; Brockett, 1997) Students in second through third year are guided during fieldwork (through feedback in their fieldwork logs and during small group tutorials) to make links between their experiences, their own values and the professional ethics that guide practice.

Fourth year occupational therapy students spend approximately five hours revising foundational ethics and ethical reasoning within a contemporary framework. Morality, group ethics and the law are juxtaposed in a series of guided questions related to a set of ethical dilemmas. This contrasts the significantly different outcomes that emerge when dilemmas are resolved within a legal/ professional stance, thus contrasted with a morality/group ethics/community law stance. The latter requires that questions be asked about the particular persons and the associations to which they belong, before considering the constraints imposed by professional rules or the laws of the land. (Koniak, 1996)

Commitment Component	Enforced		Voluntary	
	Law	Group	Ethics	Morality
Stories	Socio-legal interpretations	Group expectations	Group ideals	Personal stories
Rules	Legislation	Regulations	Group obligations	Personal commitment

The interactions of rules, stories and commitments that contribute to law, ethics and morality (Koniak, 1996)

This table is used to frame small group discussions around a variety of case studies. It is based on work being done at **Mc Master University** and has been adapted to local contextual issues. (Brockett et al, 1997)

The confounding realities of daily practice in South African hospitals, institutions and communities pose ethical dilemmas and challenge individual morality in ways that our colleagues in developed countries do not experience. Students are morally sensitive and display sound moral character but their personal power to effect changes in a morally corrupt context is however very limited.

This was the essential dilemma facing occupational therapists during the apartheid years. They were either disempowered from implementing or desensitised to the ethical dimensions of human rights. Although ethically sensitive at an individual client level, therapists were not conscientised to human rights at an individual or collective level. Apartheid rules and laws prevented therapists from listening to the personal stories of their Black clients or from responding to their own moral convictions. Apartheid group expectations valued and regulated White supremacy. The ethical dilemma for practitioners was either their voluntary or involuntary personal commitment to these legislated immoral rules. Although the enforced socio-legal interpretations of law, ethics and morality has drastically changed in the new South Africa, the realities of human rights abuses in practice and concomitant ethical and moral obligations still persist. We have to equip occupational therapists to voluntarily challenge the violations of human rights and ethics that occur in the contexts in which they work.

What can occupational therapy students do about, for example, the sodomy in male forensic wards when there is only one female nurse available for night duty owing to staff cuts in the public sector? What does a student do when staff 'turn a blind eye', seem 'blunted' and say 'it happens all the time' when she reports seeing a mentally retarded male patient raping a minor? Staff are just too overworked to care. How do they challenge a health system that abolishes occupational therapy posts at tertiary hospitals leaving countless severely burnt children to develop preventable contractures that will render them more disabled and disfigured than they already are?

When students raise these issues, we alert them to the ways in which ethical decisions may be made and how they may politically effect change at a system level. Ethics education and the moral development of occupational therapy students must empower them politically. Conscientisation has to move beyond redressing the legacy of apartheid through strategies such as the affirmation of diversity in curriculum. It must also equip

students with a sense of personal power to confront blatant human rights abuses and ethical misconduct in spite of hegemonious resistance in corrupt systems. They must feel confident in voicing their opinions, asserting pressure on governance structures to effect change and in politicising issues that warrant the mobilisation of public pressure.

A first step towards this must be professional socialisation that develops personal power through confirmation of those virtues that inspire a sense of righteous indignation. It is only when we believe implicitly and passionately in something that we are able to 'stick our necks out' and be counted. An undergraduate curriculum that encourages such boldness will have taken steps in the right direction. The U.C.T. occupational therapy department is exploring ways of transforming its ethics curriculum to produce graduates who *"demonstrate qualitatively that this new dispensation is different morally ... to stand up to be counted for goodness, for truth, for compassion and not kowtow to the powerful"* (Desmond Tutu, quoted in Antjie Krog's (1998) book, *Country of my Skull*). I believe we are on the right track. We encourage students to be vociferous in their opinions and to exercise their autonomy in the learning process.

Two graduates from our department recently, at a public address on psychosocial rehabilitation, spelt out the extent of human rights abuses against patients and staff in a psychiatric institution, and the pervasive power imbalance in the multi-disciplinary teams. This took great courage and precipitated renewed institutional effort to address some of the issues they raised. This kind of boldness was not evident amongst occupational therapists during the apartheid years and will effect transformation in all the contexts in which we work.

Conclusion

Against this background, the dissertation, which includes the Vona du Tiot Memorial Lecture, offers a perspective on transformation which, it is hoped, will redefine occupational therapy practice and training within an African context. I have argued that the success of this transformation will crucially depend on curriculum reform in training institutions. To this end, I briefly presented some transformational initiatives in curriculum reform that have recently been instituted at the University of Cape Town occupational therapy department. The next step, already in progress, is evaluation of these curricular changes.

The Way Forward

These recommendations suggest some ways in which I hope to contribute to the process of individual and collective professional transformation of occupational therapy in South Africa.

1. **Participate in professional debate**

The Vona du Toit Memorial Lecture will be published in the South African Journal of Occupational Therapy. It is anticipated that the lecture will evoke comment to which the author will reply either in letters to the Editor, or by writing further articles.

2. **Elaborate on the application of proposed transformation strategies**

I feel, in retrospect, that the Memorial Lecture was too conceptual, overly broad and non-specific, and failed to substantiate controversial ideas with practical examples. To address these discrepancies, I have been advised to follow the memorial lecture up with further articles in which, for example, the application of the proposed transformation strategies is made more explicit and more applicable to the structural, philosophical, educational and political dimensions of the profession in South Africa.

3. **Verbally present the Memorial Lecture to a wider audience**

I have been invited to present the lecture again to a local audience. It is recommended that such an event should create an opportunity for audience participation and that it might, for example, spark an interest in the development of a local occupational therapy ethics discussion group. Such a group would provide scope for the implementation of the transformation strategies suggested in the lecture and contribute to the continuing professional development of individual practitioners.

4. **Continue learning from and collaborating with our international colleagues**

In 1987 the American Occupational Therapy Association formed the American Occupational Therapy Political Action Committee (AOTPAC) and gave them a mandate to

“ ... encourage the election of qualified national office holders ... in order to promote decision-making responsive to public need for health care and services especially as pertaining to occupational therapy services; assist occupational therapists and others in organizing themselves for more effective political action; encourage occupational therapists to understand the nature and actions of their government and important political issues and to promote and strive for the improvement of government by encouraging and stimulating occupational therapists and others to take more active and effective part in governmental affairs” (Lee, 1998:166)

It is recommended that OTASA has much to learn from AOTPAC, in particular on the education of OTASA members about the importance of political involvement by the occupational therapy profession, and that we establish electronic liaison with key international figures as resources for the development of local expertise. OTASA has, to date, been actively involved, mainly in the remuneration bargaining chambers. This politicisation must be extended in the interest of more pervasive transformation. I have for example, established electronic links with the ethics research team at Mc Master University in Canada (Brockett et al, 1998). It is recommended that collaboration in undergraduate occupational therapy ethics research be further developed.

5. Communicate the results of research into the reflections of occupational therapy students on their fieldwork experiences.

This will be done in order to uncover domains of moral sensitivity and ethical concern (Protocol accepted by the Faculty of Health Sciences Research Ethics committee in March 1999). In keeping with the dialectical research cycle, the results of the above-mentioned research will be published in the South African Journal of Occupational Therapy. The writing of the memorial lecture and minor dissertation enhanced the pilot phase of this research, adding depth to the author's insight into the students' reflections. The author is currently busy with a thematic content analysis of certain sections of students' fieldwork logs and anticipates finalising this research in the near future. It will hopefully result in further collaboration between the three regional occupational therapy training centres (students were sampled from all three departments) in the development of a contemporary approach to ethics education inclusive of a human rights orientation. Section 27 of the Bill of Rights in the South African Constitution entrenches health rights within one of the most substantive legal frameworks through which fundamental socio-political change can be effected. It is recommended that occupational therapy ethics education should equip graduates with a thorough knowledge not only of professional ethics, but also of the Health Rights Charter, and provide them with the skills to help individuals and communities understand, interpret and promote their health and human rights. (National Progressive Primary Health Care Network, 1997)

6. Participate in Faculty of Health Sciences Equity and Transformation Portfolio.

The faculty of health sciences has launched an equity and transformation plan aimed at redressing the inequities of the past. The department of occupational therapy should play a substantial role in the implementation of this plan as well as in the development of a multidisciplinary undergraduate ethics and human rights curriculum.

Appendix 1

June 99

May 99

Table 9.2 Point : BEING

Efficiency questions

- Is E familiar with the field and its literature? ✓
- Is E actually involved with the relevant data? ✓
- Has E got appropriate qualifications for dealing with the relevant matters? ✓
- Does E have dependable work habits? ✓
- Is E intelligent enough and intellectually tough enough? ✓

Authenticity questions

- Is E aware of her own motives? ✓
- Is E questioning her involvement with the field? ✓
- Does E work in a self-punishing way? ✓

Alienation questions

- What relationships with others does E set up by her way of being? ✓
- Can E listen to others? ✓

Political questions

- Is E aware of the social implications of her daily practice? ✓
- Is E aware of the sources of the money which supports her? ✓
- Is E aware of the social pressures which influence her actions? ✓

Patriarchy questions

- Is E sexist? racist? classist? ageist? ?
- Does E conduct a great deal of her life in terms of domination and submission? ?
- Competition and acclaim? Struggle for recognition? ?
- Is E aware of the patriarchal patterns which surround her? ?

Dialectical questions

- Does E look for the contradictions underlying daily experience? ✓
- Does E take responsibility for her own life? ✓
- Does E perceive the world in terms of conflicts and their resolution? ✓
- Does E see the paradox of rhythm and the rhythm of paradox? ✓

Legitimacy questions

- Is a client involved? If so, is there honesty or deception or lack of communication between E and the client? ?
- Who provides the problem? Who defines what the problem is? Who owns the problem? Who legitimates the problem? ?
- Who is the client? And who is the real client? ?

Relevance questions

- Am I choosing a problem that is relevant to my life? my career? a client? ordinary people? questioning patriarchy? the advancement of science? a class of problems? my unconscious? ✓
- What am I really trying to do? promote professional humaneness

Table 9.3 Point : THINKING

Efficiency questions

- Can E marshal and correlate information in such a way as to bring it to focus on a problem? ✓
- Does E define and break down the problem into specific researchable questions? ✓
- Does E use creative imagination to think of interesting and usable hypotheses? ✓
- Can E discriminate between more and less central or crucial hypotheses to test? ✓
- Can E use the library in an efficient way to gather existing data? ✓
- Has E got the stamina to pursue what she wants in the abstracts and reprints? ✓

Authenticity questions

- Does E believe that she can be value-free? ✓
- Does E separate research from the rest of her life? ✓
- Does E have something to gain or lose from the solution of the research problem, in a direct practical personal way? ✓

Alienation questions

- Does E consult with others on a strict role basis? ✓
- Does E home in on a specific question early, and spend the rest of the time defending that selection? ✓
- If E disagrees with others on a point, does she fall for a veto? ✓
- Does E consult authorities to gain new knowledge or insight, or to back up what is being done already? ✓

Political questions

- Does E check on the political commitment of sources of information? ✓
- Is E aware of the social implications of certain lines of inquiry? ✓
- Does E refuse to be politically isolated in her work? ✓

Patriarchal questions

- Does E take patriarchy for granted? ✓
- Does E draw attention to patriarchal patterns when she discovers them? ✓

Dialectical questions

- Is E consistently adopting a reflexive approach -- applying her concepts to herself? ✓
- Is E looking for the reality beneath the appearances? ✓
- Is E looking for the major contradiction underlying her problem? As opposed to minor contradictions which may be easier to approach? ✓
- Is E questioning or reinterpreting positivist research findings? ✓

Legitimacy questions

- Is information being fed in from an interested party? ✓
- Is there pressure not to study certain problems? ✓ X? defensiveness
- Is certain information refused or 'not available'? ✓
- Are certain lines of thought discouraged? ✓

Relevance questions

- Am I looking for the data about how my problem can work out in practice? ✓
- How application has taken place? ✓

Appendix 2

Introduction to the 17th Vona du Toit Memorial Lecture by Estelle Shipham (past recipient of the award and currently head of training at Medunsa)

(Speaker's Original Notes)

I thank you for the opportunity, tonight, to say a few words about the Vona Du Toit Memorial Lecture - its origin & purpose.

By being here tonight each one of us will be paying tribute to one of the great contributors to the development of the OT profession in SA & also internationally.

Tonight's prestigious lecture will be delivered in memory of the great Vona Du Toit - at the same time honoring a person whom the OT Association of SA has identified as a prominent OT. This person will join 16 others who were similarly honoured over the last 23 years, as being prominent OTs or medical persons with an intimate knowledge of OT. Of these 16 persons not all were OTs by profession as a matter of fact the second memorial lecture was delivered by the first President of the Association - an orthopaedic surgeon. Three others were also not OTs. These included a former principal of Medunsa, a physician who was also an advisory board member of OTASA and a member of the Professional Board of OT. Other prominent non-OTs included the Director of the National Council for the Blind, a former Director of the Health Services in the previous Cape Provincial Administration. All except the first lecture were delivered by South Africans. This first lecture was undertaken by ms Alicia Mendez, the then President of the WFOT - a British OT with international standing and a very good friend of Vona's.

The other 11 persons were all SA OTs, each of whom had inspiring yet different messages to deliver.

Tonight I see many persons who knew Vona as a colleague, as a teacher, as a boss and as a very dear friend. I also see younger persons who never knew Vona personally - who entered the OT scene after Vona's untimely death in September 1974. This 'younger generation' knows about Vona, mainly through her theory on Volition & Action - a central theory taught at most of the OT training centres in the country. Further than that, most OTs do not hear or know much about her. Few might know about & remember her for paving the way for the OT profession to get the recognition it deserved. Vona was a very charismatic person. She was charming, dynamic, magnetic & spellbinding and she believed in OT. She persuaded the powers to be - especially in the previous Transvaal Hospital Services Department - that OT should take its rightful place in the health services in the province. Given one year to prove that OT was a profession which needed to be developed & supported, because it made a difference to the health and well-being of

persons, she persuaded the authorities that the Pretoria College should continue its training of OTs.

As the simultaneous President of the OT Association, Chairman of its Education Committee, Chairman of the Prof. Board, SA delegate & Vice President of the NYFOT & delegate to the National Council for the Care of Cripples in SA, Vona was indeed a most productive & influential person.

Yet, only those of us who knew her personally can vividly recall the contribution she made to the development of OT. We also have a deep appreciation for the effect she had on our professional and even personal lives.

However, by arranging this prestigious event every second year, OTASA wishes us, who were fortunate enough to have known her & those who were less fortunate, to be reminded of Vona and to honour her memory.

As many of you might know, it is not unusual for a profession to honour the memory of one of its outstanding contributors in this way. Many of you might have read some of the Muriel Driver Memorial Lectures which are presented in Canada & published in the Canadian Journal of OT. Interestingly enough Vona & Muriel Driver were also great friends. We also know about the Elizabeth Docker Memorial Lecture in Australia. In the USA there is the Eleonor Clarke-Slagle lecture in honour of one of the pioneers of OT in the USA and in the world. Also in Britain there is the Elizabeth Casson memorial lecture.

Joining the ranks of the other prestigious international OT memorial lectures is then the Vona du Toit lecture, which is then also published in the S A Journal of OT. Unfortunately the initial few lectures were never published, but are kept in the archives of OTASA for perusal by those interested.

Tonight I urge those of you who knew Vona & those of you who knew about her; and in particular those of you who have heard about her for the first time tonight, to remember her as a person who implicitly believed that all human beings have creative potential; and that OTs in particular could elicit this potential through careful nurturing of the person's volition. In particular OTs could elicit creative action through engaging the person in activities particularly suited to his/her needs.

In her dissertation on Initiative in OT, Vona defines it as a quality of self application, self-directedness, self-expectation in a new situation, which if applied with dedication leads to self-fulfillment, self-confidence & intentionality to finding creative solutions to difficult problems. This is indeed a powerful message which still applies today.

The Vona du Toit Memorial lecture then serves the purpose to remind us of Vona, the great S African OT philosopher of the 20th Century. In addition, it gives us an opportunity to listen carefully to the message brought to us by each subsequent eminent philosopher of the OT profession in South Africa.

I thank you for your attention.

Appendix 3CLASS CONSTITUTION• PREAMBLE

First year UCT OTs of 1999

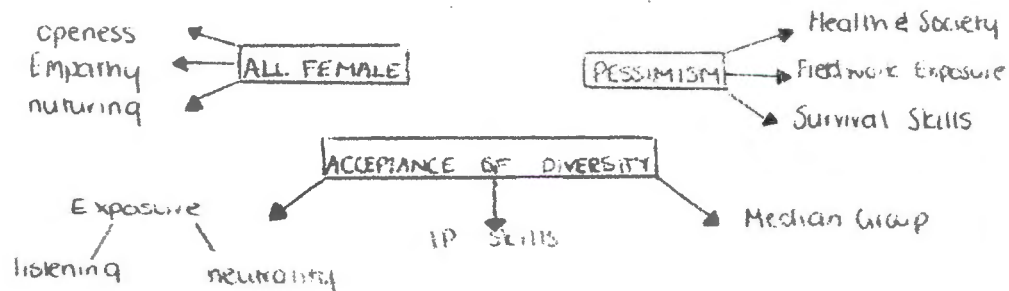
• PURPOSE

In unity, with compassion, we strive to work hard, play hard and embrace diversity. We aim to utilise our skills and experience to attain self actualisation through exploring ourselves as individuals and as a group

• ProcessSTRENGTHSWEAKNESS

◀ ALL FEMALE ▶

- | | |
|---|---|
| • socialise together | • Acceptance of diversity - |
| • Diverse experience and cultural backgrounds | different abilities & opinions |
| • Motivated | • Listening |
| • Compassion | • Neutrality |
| • Small class - intimate | • Pessimism (Re : other professions perception of OT) |
| • Debate | • Learning how to learn |
| • Self exploration | |

• OPPORTUNITIES

DEFINITIONS

- Learning how to learn
 - Experience
 - Mind mapping
 - Critical Thinking
 - Academic Tutorials
 - IP SKILLS.
- Motivation → will / drive to strive for a goal
- Compassion → being sensitive to the emotional needs of others
- debate → discussion and sharing of ideas to explore a topic to come to a deeper understanding
- Self Exploration → (self-actualisation) / making a journey of self-discovery in order to fulfill your potential. Process of realising your creative talents. The self-actualisation of a group
- Acceptance of diversity → Accepting that everyone has different talents, abilities, personalities, needs etc
- Pessimism → expecting the worst
- learning → active process of acquiring knowledge with a deeper understanding.

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