This life history of an occupational therapist traces her evolution from a biomedical technician to a 'detective', who searches for new ideas that will support clinical practice and enable the profession to achieve its potential contribution to humankind. These ideas focus on 'homo occupacio', the occupational human: an agent who sets goals, makes choices and becomes competent through engagement in occupation. Concepts such as motivation, self-organisation, skill development, resource reclamation, brain evolution, repertoires of daily routines, environmental management and defining health as the capacity to achieve one's valued goals illuminate occupation. The contexts in which people carry out their rounds of occupation also require study in order for occupational therapists to pose a 'just right' level of environmental challenge, enabling people to make an adaptive response in user-friendly environments. Recommended sources for new ideas are, first, self-reports of people who live with impairments and, second, literature from non-medical disciplines that share occupational therapy's holistic, integrated and optimistic view of people.

The writings of people who live with chronic conditions reveal that they are not being served well by the current biomedical system. In contrast, scholarly detective work could foster occupational therapy that enhances satisfaction in daily living, influences health, reclaims resources and enables equality of capability for myriads of the world's populations.

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Confessions of an Occupational Therapist who became a Detective

Elizabeth J Yerxa

Introduction

I want to share some images from the past that have influenced how I think and what I do today as an occupation. In a way this is a confessional, in which I hope to share both my shortcomings and my epiphanies as a member of this exciting profession.

I shall begin with critical incidents from my professional education, then move to some early clinical experiences, graduate schooling, work in academia and finally my current life, especially as it reflects my hopes and dreams for occupational therapy. I want to recount how I became a 'detective' (to use Mary Reilly's term) and what became the target of my sleuthing and why.

Assumptions

Before beginning this life review, I need to share two important assumptions. First, occupational therapists, internationally, primarily serve people with chronic, irremediable impairments, those who are 'incurable', as well as people who are trying to stay healthy. Second, true professions are work groups that define their own realm of practice based upon their own values and configuration of knowledge (Blane 1991).

Professional education at the University of Southern California (SC)

When I chose to enrol at SC in 1948 I had one goal in mind: to prepare for an interesting job that reflected my personal objectives and interests. Education was job training. Although I was required to take liberal arts prerequisites, such as Man and Civilisation, literature, philosophy, psychology and sociology, I considered these interesting but not really relevant to what I imagined my work would be as an occupational therapist.

In my third year I was thrilled that now I could finally concentrate on learning to be a 'real occupational therapist'. Our faculty members were primarily occupational therapists and physical therapists with a smattering of physicians and psychologists. I viewed the occupational therapy staff as

former clinicians who had decided to teach what they knew of practice. Most courses were rather 'soft', time consuming, commonsensical and insufficiently challenging to require much reading or critical thinking. The only theoretical construct that I now recall from my undergraduate education was 'play is the work of the child'.

By contrast, the substantive, demanding courses (anatomy, physiology, kinesiology) were taught by eminent physical therapy faculty members. Examinations required memorisation of muscle origins and insertions, dissection and identification of structures on a cadaver and prediction of a patient's dysfunction from manual muscle test records. I sometimes resented the time required to learn to do arts and crafts since it was stolen from that needed to do well in the 'hard' stuff.

From these experiences, I developed some impressions. The fundamental knowledge supporting occupational therapy was the same as that grounding physical therapy and medicine, namely the physical and natural sciences. In occupational therapy, activity (now called 'occupation') was added onto the physical modalities as a sort of motivational magnet. Arts and crafts were analysed according to kinesiological principles to make them 'therapeutic'. Medicine was our model and physicians were our idols. (For example, we were taught to stand when they entered the room.) The closer we could approximate medical thinking the better. I was proud that the definition of occupational therapy included the phrase 'medically prescribed', because it legitimised what, on the surface at least, appeared to be a mere occupying of time with trivial activity. 'Diversion' was never a priority in the medical milieu since it was considered wasted time.

Early clinical experiences

At last I was ready to begin my clinical affiliations (as they were called then) under the supervision of real, practising occupational therapists. These experiences were awesome, as we say today. I awakened to the realisation that each patient was a complex and unique human being, not just a disability embodied. I can still see the face of a 7-year-old girl with severe burns over 80% of her body. She was not expected to live, was in constant, agonising pain and was unable to move. As a student, what could I possibly propose that she could do? We played imaginary hide and seek in her hospital room and when I couldn't find her (by successive guesses) I heard her laughter overriding the pain. Thus I learned something about play and human motivation, for example, how play could block out excruciating pain by dominating consciousness.

I was often overwhelmed by trying to find some way for a person with almost total incapacity to act. I searched books for ready-made solutions and found none that fitted the unique people assigned to me.

I was intrigued by the mystery of mental illness and sometimes outraged by how such patients were treated. For example, a bright but anxious high school teacher became totally aphasic as a result of a prefrontal lobotomy. Today I can still visualise her intelligent eyes, trying to communicate what she could no longer express in speech.

While training in psychiatry at one of the world's most prestigious university hospitals, I encountered theory. The hospital used Freudian psychodynamic theory as the conceptual basis for treatment. While on ward rounds one day I asked, 'If we believe in a Freudian approach here, why are we using physical interventions such as insulin shock, electroshock therapy and lobotomies?' My question was met with icy silence accompanied by pained facial expressions that telegraphed the message, 'Who is this cheeky upstart anyway?' Somehow I received a passing grade.

Early work experience

My first job was in an outpatient clinic for children with cerebral palsy. We treated each patient for 30 minutes using a neurodevelopmental approach, including stretching, crafts for eye-hand coordination, sensory stimulation to reduce spasticity and some feeding training. I devised a home treatment programme for each patient, instructing the mother in how to carry it out. I felt very secure in my role and enjoyed the concreteness of every treatment. My security superseded the need to read about what I was doing, although I continued to be an avid reader of literature, psychology and philosophy, out of curiosity and habit.

A few years later, I took a position providing occupational therapy to children with cerebral palsy who lived in rural areas of the Mojave Desert. This experience created a radical awakening. I discovered the impact of the social and physical environments, the *contexts* in which these children lived and carried out their rounds of daily activity. Real life context had been invisible to me in the hospital world. I saw that the mothers were often overwhelmed, had other children to attend to and could not begin to carry out the home treatment programmes that I had been prescribing so blithely. All the family members needed help to survive and develop their capabilities, but very little assistance was available. The real life environment was where the kids needed to function and it provided immediate feedback about their capability to them and to me.

Rehabilitation centre

A major impact on my career was working as a clinical instructor in a world-class rehabilitation centre at the zenith of its international influence. This centre served people with the most extensive disabilities that I had ever imagined. Many could only move a few muscles, needed respirators for breathing and had to be suctioned to remove secretions from their airways. Their situation was similar to that described by Beisser (1989). At first, all our patients had poliomyelitis, but later the rehabilitation programme expanded to include patients with spinal cord injuries, arthritis, head trauma, stroke and other severe and chronic disabling conditions.

I worked in this centre occupying different roles for 16 years. The social context was one in which powerful orthopaedic surgeons directed a cadre of therapists. Next to the physicians, the physical therapists enjoyed the highest status. The physicians made their expectations very clear. They ridiculed arts and crafts. Our job was to deal with the physical body and enable it to function through mechanical, technical interventions. (I later discovered that such demands reflected how physicians were taught to think.) I believed that occupational therapists had to conform to these expectations in order to gain professional respect.

The manual muscle test symbolised the Rosetta stone of knowledge; therefore, I learned to do muscle testing of the upper extremity and taught the other occupational therapists how to do so. We learned to apply many techniques, such as splinting, exercise, range of motion and progressive resistance exercise to the upper extremity. In essence, as I see it now, we made ourselves into physical therapists for the upper extremity, with some additional emphasis upon training in the activities of daily living. We became highly specialised, valued technicians, but still *not* as respected as physical therapists.

For the first 10 years, this scenario fitted well with my undergraduate education at SC. I was living out a destiny grounded in the belief that the physical sciences and their concreteness united occupational therapy with medicine and dictated our role and practice. This view was reinforced by powerful physicians who demanded conformity to their mechanistic thinking. Since engagement in occupation seemed so trivial, it could be comfortably eliminated in the service of measurable, physical gains, such as range of motion.

At certain moments, however, I had vague feelings of unease about what we were doing. When I saw the strength and resiliency of the human spirit demonstrated by people who picked up their lives again in spite of the overwhelming challenge of chronic, severe disability, I was awestruck. What was it about humans that enabled them to continue to be competent mothers or workers or students? Whatever this spirit was, it didn't seem to be recognised, fostered or enhanced by the rehabilitation environment, which focused on disability, mechanical aids and medically valued accomplishments (Vash 1981, Bickenbach 1993).

My Eleanor Clarke Slagle lecture (Yerxa 1967) described some of these nascent concerns. Patients were valued, in my rehabilitation experience, primarily for their conformity to medicine's beliefs. For example, patients with quadriparesis were showcased to hospital visitors, demonstrating how they did lower extremity dressing, even though this left them exhausted for the rest of the day. 'Good patients', who conformed, sometimes became passive and vegetative upon discharge to their homes and communities.

The rehabilitation programme seemed to foster just the opposite of what it intended: patient dependency, conformity, socialisation into the lowest status of 'the disabled' and emphasis upon what was wrong rather than identifying and enhancing what was right (Vygotsky 1976). Almost all our evaluation tools sought to detect pathology which we would attempt to fix, in the mode of acute medical care (Wright and Fletcher 1982). But, our patients never recovered, were never physically 'repaired'. The rehabilitation centre thus symbolised the patient's rite of passage, a doorway into a new frightening world of chronicity and liminality (Murphy 1990).

The tools of acute care and technical aids seemed feeble indeed, even wrong headed, to enable these people to deal with the enormity of the challenges of living their daily lives in the real world. Hence, I cited Rilke's (Norton 1938) poem at the end of my lecture: our efforts, as therapists, seemed as 'feeble fountains'. I began to see beyond the physical deficits of humans to seek their authentic existential strengths and potential for choice and agency.

Graduate school

In 1966, I decided to enter graduate school because I recognised what an automaton I was becoming on the job. I hoped to rekindle my curiosity and discover new ideas that could be incorporated into practice, for example, through the development of new valid and reliable, more scientific assessments. I was accepted into a doctoral programme in educational psychology. Skinnerian behaviourism (Skinner 1971) was a major paradigm in psychology and education. Consequently, my doctoral supervisor was a true believer in reductionistic, stimulus-response theory, which she believed should be applied to every aspect of education including that of university students. The human mind or consciousness was considered either scientifically irrelevant or as an unknowable 'black box'; therefore, education was to be designed and evaluated according to how well it elicited desirable behaviour.

Since about 50% of my doctoral study was elective, I chose philosophy and psychology as my minors. These proved to be good tools in opening the windows of my mind and letting fresh, new ideas awaken my questioning spirit. I was extremely sceptical of behaviourism and its reductionistic claims of truth, but especially its denigration of people into simplistic, stimulus-response robots. I have remained sceptical of all such scientific theories that try to explain the human condition by robbing people of their minds, social contexts, histories and agency (for example, see Dawkins 1989, *The Selfish Gene*).

While expanding my conceptual horizons in graduate school, I also developed an experimental preschool programme for indigent children with disabilities at a public housing project. This resulted in another awakening to the significance of social context, economic status and culture on the life opportunities available to human beings (Lewontin 1993). I saw deprivation on a grand scale (youngsters who had never seen themselves in a mirror, observed a plant growing from a seed or flown a kite on a windy day). I also witnessed the vicious cruelty that can be perpetrated by and on the socially downtrodden. Nathaniel, age six, was attacked on his way to my school by a pack of older boys who removed his leg brace and beat him over the

head with it. Concurrently, the Age of Aquarius was promoting new equality of opportunity, freedom and choice for all citizens.

My doctoral dissertation developed into a study of one component of the social context of disability, referred to as 'social attitudes' towards people with disability. I had to design it as an experimental, statistical study to satisfy my supervisor. But I adopted a broad, humanistic foundation of attitude theory. During my investigation of the literature, I encountered the voices of people with disability for the first time (Yuker 1988), although most of the work on attitudes still treated people with disability as objects rather than subjects. I discovered that people who lived with disabling conditions had many important insights about their daily life experiences and needs, which should inform occupational therapists since our profession centred upon daily life activities. I also discovered the limitations of experimental method when applied to complex, social psychological issues.

Academic career

I returned to SC in 1976 with a doctorate and a new title, Associate Professor of Occupational Therapy and Chair of the Department. I now consider this my fools-rush-in period. I was incredibly naïve about the university environment; rather, I was a former clinician now with a graduate degree, one who felt that educators needed to do a better job of preparing students for practice. At first I tried to apply my knowledge of statistics and instrument development to occupational therapy education, practice and research, intending to make them more 'scientific'. However, since Mary Reilly and Harriet Zlatohlavek had preceded me at SC, I kept encountering their ideas and reading the work of their graduate students. I also saw that our profession was much broader than practice alone. We needed to integrate new ideas, research and education with clinical work in order to *nurture* practice (Yerxa 1991).

In my daily experiences as a Department Chair (who was also having to produce scholarly work for tenure), I discovered the whole new world of the university of which I had been previously unaware. In a way similar to the rehabilitation environment, occupational therapy was poorly understood, had low visibility and was a greatly endangered species in academia (Yerxa 1991). For example, faculty members from other departments often called us 'physical therapists', our classrooms and facilities were old and deteriorated, our library was inadequate, and we were physically and socially isolated from other university departments. Many other departments didn't even know we existed. Sometimes I would wake up in the middle of the night in a panic, fearing that our programme would not survive.

Early in my career at SC I had my first contacts with Paul Longmore, Sandi Burnett, June Kailes and other representatives of the independent living movement, a movement by and for people with disabilities designed to improve their life opportunities (Crewe and Zola 1983). This fired my imagination regarding the need for a partnership between our profession and people with disability. This union could pursue the twin goals of assuring the relevancy of occupational therapy to the self-perceived needs of people with disability, as well as using our knowledge to promote advocacy and social justice.

I gradually learned, with the help of a great deal of study and insightful faculty members, what we needed to do to become an academic discipline. To be a viable, contributing academic department, we as faculty and students needed to engage in demanding scholarly work. This would develop new knowledge both to contribute to the universe of ideas and to support occupational therapy, so that it could better serve society and achieve its rich potential. Occupational therapy could become an autonomous, self-defined profession only to the extent that we developed our own ideas, our own perceptions of service, and translated these into a curriculum (Yerxa 1995). I realised that Mary Reilly, the former director of occupational therapy graduate studies at SC, had been trying to do just that during her tenure. She served as one role model of a faculty member who was a brilliant scholar and who also created a community of scholars consisting of faculty, graduate students and clinicians. Together they developed the occupational behaviour frame of reference (Reilly 1969) which served as the foundation for both a curriculum and new models of practice. Many of her former students have since become leaders, master clinicians, scholars and academics. It worked!

Although I was never her student, Mary Reilly inspired me by her example, wisdom and life as a born academic. I can visualise her emerging from the womb exclaiming, 'Forget the milk, bring me my literature!' She referred to scholarly endeavours as 'detective work', an occupation I soon adopted. I have evolved from clinician to detective in 47 years, from a technician to a person who sleuths out ideas, knowledge and wisdom wherever they might be found, finding clues and following trails.

My own detective work has led me into an exciting investigation of ideas from an array of non-medical disciplines, for example, evolutionary biology, psychology, sociology, anthropology, economics, history, political science, management theory, disability studies and philosophy. I do this sleuthing to help to broaden and strengthen the knowledge base of occupational therapy so that our practice can more effectively serve the needs of people with chronic conditions, in danger of developing health problems or in need of new skills in order to survive (Yerxa 1993).

Occupational science

At SC we called the resulting synthesis of ideas 'occupational science', focusing on the study of the human as an occupational being: 'homo occupacio' (Yerxa et al 1989). This person has resources and strengths which, when actualised through occupation, enable an adaptive response to environmental challenges in a culturally congruent way. Obviously, occupational therapy, viewed from the perspective

of homo occupacio, deals with very complex and significant stuff; hence the need for broad-based detective work and new syntheses. It responds to such existential questions as: How will I survive? How will I contribute? How will I connect with my culture (Beisser 1989)? How will I become an autonomous, valued member of society, even though I might have an impairment, a disability or a handicap? How can I find and engage in something that I believe is worth doing during the hours, days and years that constitute a human life span (Vash 1981)?

Does this emergent occupational science require that occupational therapy file a divorce from medicine? I don't think so. Rather, it suggests a new, vital relationship in which occupational therapists are able to speak the language of medicine and understand its thought process, grounded as it is in the natural sciences. *But*, we contribute to the relationship by developing and strengthening our own thought process, by focusing our detective work and practice on the occupational human within a physical and social context. Our optimism perceives those we serve as having interests, abilities and resources as well as facing challenges (Meyer 1922, 1977, Montgomery 1984).

Medical technique has an important contribution to make to body machinery, but it doesn't eliminate chronic disabilities or erase social handicaps nor is it its business to identify potential. That's where we come in.

By interacting with hundreds of clinicians and students, I developed the greatest respect for occupational therapists who are able to break free of the technical, mechanistic thinking surrounding them in a medical setting and, instead, pursue a different course. Autonomous thinking enables such master clinicians to welcome complexity, engage in the innovative problem solving required to foster occupation and enter the subjective world of each individual human.

It is most difficult to change one's way of thinking, for old ideas are persistent. Once I was imbued with medical thinking during my undergraduate education and clinical experiences, I found it almost impossible to view our professional roles and the people we serve in a different way by putting on a new pair of perceptual glasses. My old ideas were my enemy, luring me back to simple, linear causality, decontextualisation, hyperobjectivity and the security of independent and dependent variables (Gergen 1982), especially when faced with difficult research and practice issues. This 'stuckness' was similar to the venerable Gestalt experiment. I could see *only* the vase, never the profile, because of my prior socialisation. Such perceptual sets are a major obstacle to our professional growth and development.

What kept and now keeps me going was inspiration from two major sources:

1. The reports of people with chronic impairments who criticised the traditional medical system because it often failed to meet their needs (Zola 1982, Murphy 1990)
2. The great scholars who, through their writing, became my mentors in thinking about the complexity of occupation: healthy and satisfying engagement in the life and routines of one's culture (Csikszentmihalyi 1975, Bruner 1990).

Occupational science: doctoral programme

In recognition of both the potential and needs of occupational therapy, our community of scholars at SC decided to develop a new doctoral programme which reflected our particular vision of the knowledge needed to support practice (Yerxa et al 1989). The graduate school agreed that this study was sufficiently rigorous and scholarly to warrant awarding a Doctor of Philosophy degree in occupational science (Yerxa 1993).

Some of our specifications for the knowledge needed to support occupational therapy practice were these. Our knowledge needed to reflect a new, interdisciplinary synthesis of ideas grounded in occupational therapy's traditional values, not those of the natural sciences. Our profession would thus be defined by us, not by medicine or any other discipline, assuring sufficient autonomy of thought and practice to enable us to develop our own profession to serve others as we see fit based on our knowledge. Our detective work would enable practice to achieve new relevance to both the people served and the unmet needs of society. This knowledge, from an array of disciplines including science, liberal arts and philosophy, would apply to all human beings, not just those with impairment. Thus it would avoid the unintended consequence of separating those we serve from the mainstream of society because of overemphasis upon pathology and deficit. As a human science, occupational science would need to employ a different way of knowing from that of the physical sciences since once human consciousness evolved, genetic determinism lost out to human motivation (Lewontin 1993).

If we did our job as educators well, occupational science would help to create a cadre of scholars who would become lifelong detectives, searching for new ideas that could illuminate occupation, an essential component of every human being's life. My vision of occupation includes all self-initiated, self-directed activity that humans do to achieve a healthy goodness of fit with their environments and adapt to its challenges. As such it must engage the whole person, consisting of his or her biological, psychological, sociocultural and spiritual levels of being, not just muscles, joints, cognitions or psyches. Occupation is contextualised in that it affects and is affected by the environment. It requires organisation and integration of effort in order to respond to challenges (occupations have a beginning, a middle and an end). Thus the study of occupation is much more complex than simply understanding kinesiology and neurology. It elicits or is driven by human motives (Csikszentmihalyi 1975, Burke 1977) and, in becoming actualised, develops skill. Engagement in occupation permits the self-assessment of the adequacy of skill to produce a desired effect so that the individual is in charge of and conscious of his or her own performance. It changes the person-environmental interaction in the service of adaptation.

Sleuthing for evidence to support occupational therapy

I am now a full-time detective, as obsessed as Sherlock Holmes with tracking and uncovering the evidence that will support occupational therapy. Here is my modus operandi.

Homo occupacio

I want to address the person as an agent. Let us learn more about how people set goals, make conscious choices, define themselves and become responsible for themselves through engagement in occupation. How do they become effective managers of their own environments by orchestrating their occupations in daily life? How do they use their time to achieve a healthful nexus of individualised occupations while fulfilling societal expectations?

The occupational human has unique interests providing motivational energy to engage in occupation and withstand the frustration of trying to learn new skills. We need to study the development of interests, exploration, curiosity, the search for novelty and the active seeking for challenge often subsumed under 'intrinsic motivation' (Csikszentmihalyi 1975, Burke 1977).

Homo occupacio is a self-organising system who responds to specific environmental challenges with occupation, creating an adaptive response. Successful self-organisation creates skill which will be available in the face of new, unknown challenges.

The individual appears to develop and modify a unique nervous system by engagement in occupation (Edelman 1989, Donald 1991, Deacon 1997). In this sense my occupation literally helps to construct who I am, since occupation and the brain develop cooperatively. Parenthetically, new insights from evolutionary biology might cast doubt on the low value that our culture holds for engagement in non-work occupations, such as music and art. These 'diversional' activities may actually contribute to the development of new neural networks, which add significantly to human capability in such highly valued endeavours as mathematics. We have vast canyons of ignorance about how occupation contributes to the development of the mind. New understanding of how the self-organising brain evolves might apply to how occupational therapists sequence occupations for people with impairments, suggesting new ways to pose environmental challenges that achieve capability.

The occupational human has skills and resources as products of evolution, development and learning (Montgomery 1984). Thus I search for what people might be capable of doing rather than only their deficits and pathologies. I view homo occupacio in an optimistic light, as did Meyer (1922, 1977), Reilly (1962) and Vygotsky (1976), asking: What can this individual do that he or she believes is worth doing? What strengths and resources are available?

The occupational human engages in daily life through the development of a repertoire of skills that adheres to the rules of culture, employing habits to conserve energy. Such repertoires enable people to manage their own environments (Osborn 1998). Therefore, I want to learn more about the daily routines that enable people to do what they need and want to do to find their place in the culture (Beisser 1989). Osborn (1998), a young physician who acquired a disability due to head trauma, provides a rich example of why we need to understand the orchestration of daily routines. Although she completed two stints of cognitive rehabilitation in one of the top centres in the USA, the programme did not provide guidance at home or in her community so that she could accomplish the daily routines necessary for her survival in the real life environment of New York City. She often went to bed hungry because she had botched shopping. 'I didn't have the psychic energy, planning ability or decision-making capacity to take advantage of this wonderland [New York City]' (Osborn 1998, p69).

Our concept of the activities of daily living needs to be broadened beyond self-care to include the entire repertoire of daily routines. We need to become ardent students of all of life's daily activities.

My detective work follows the trail of a new view of health contrasting with the traditional one of freedom from impairment or pathology. For example, in Sweden I learned of Pörn (1993), an existential philosopher. He proposed that health was achieved when a person's repertoire of skills enabled him or her to achieve vital goals within a specific environment. This news excites me because it admits people with chronic impairments to the realm of health and social participation. It helps us to understand how our work, designed to enable those with impairments to develop a repertoire of skills, destigmatises them and enables them to be and to be perceived as healthy, functioning participants in their own culture.

Environment

As a detective, I need to study the contexts in which people carry out their rounds of occupation. The environment may be examined from multiple perspectives (or levels) according to its demands or resources. In achieving a goodness of fit, a person needs to respond to physical, psychological, social, cultural and symbolic-spiritual challenges in his or her surroundings by engaging in occupation. A central issue for me is understanding the 'just right' level of environmental challenge. This is the appropriate demand as ascertained by the person's ability to respond successfully and thereby develop skill. By better understanding how to pose this degree of challenge, occupational therapists would not only enable people to learn competence but also tap into their evolutionary strengths and resources.

Environments embed challenges, difficulties and demands but also provide 'affordances' (Gibson 1988) or, as Meyer (1922, 1977) said, 'opportunities'. Knowledge of discovering and creating these could provide new insight into the essence of clinical practice: the ability to establish a challenge which doesn't overwhelm or underwhelm but fosters an adaptive response at a given point of time in the

real world. Creating such a challenge in the context of unique personal and environmental differences is a keystone of the knowledge applied in practice.

We need to learn much more about how to structure environments that are user-friendly for all people, including those with impairments. Members of the Independent Living Movement have urged public policy makers to view disability not as residing within people but, rather, as a primary deficit in the environment which limits their capability. Detective work on the environment could fuel advocacy efforts to create more user-friendly environments worldwide.

Conclusions

My journey from being a student who viewed occupational therapy as technique embedded in the medical sciences to my current status as an occupational science detective has been rich and rewarding. Through the literature and in real life I have been moved and inspired by great spirits, first by people who lived with chronic impairments and who eloquently told the truth about their experiences and, second, by scholars who demonstrated values and ways of knowing that were compatible with the glorious humanistic traditions of our profession. These values include holism, optimism about potential, environmental contextualisation, tolerance for complexity, emphasis upon the individual and the validity and significance of subjective experiences including consciousness (Searle 1992).

What has this detective learned from people who have impairments, disabilities and handicaps?

- An almost universal voice reveals that those who have chronic, irremediable impairments are not being served well by current rehabilitation programmes, which often foster dependency and compliance rather than autonomy
- The medical approach of fix and cure is inadequate for those who must live out their lives with the triple challenge of handicap, social stigma and environmental unfriendliness
- Their self-identified, unmet needs for 'equality of capability' (Bickenbach 1993) are deeply congruent with the traditions and values of occupational therapy (Meyer 1922, 1977)
- Our skill, supported by new knowledge from the human sciences, philosophy and the liberal arts, has the potential to improve life opportunities for these individuals on a worldwide, unprecedented scale as well as to stoke the fires of social justice through our partnership and advocacy.

Every individual's story I have read, without exception, identifies negative consequences of medical thinking as well as unmet needs for autonomy, self-organisation, temporal and environmental management, resource identification and reclamation and, as Clark et al (1997) observed, 'life-style redesign'. These are all potential outcomes of thoughtful, reflective, informed occupational therapy.

What have I learned from scholars who share our values? I am deeply inspired by the example of Mary Reilly who lives to learn and by other great minds such as Jerome Bruner, Gregory Bateson, John Dewey, Richard Lewontin, Viktor Frankl, L S Vygotsky, William James, Ingmar Pörn, Adolph Meyer, Kenneth Gergen, John Searle, Terrence Deacon and Jerome Bickenbach. These thinkers often resisted social pressure for reductionism and positivistic thinking by presenting truly original, revolutionary world views. Their work, from philosophy, biology, anthropology, psychiatry, psychology, social psychology and mind theory, demonstrates how almost all fields of inquiry may contribute to the knowledge needed for occupational therapy, provided that they are based upon a congruent view of human beings.

They have taught me that education is not job training; rather it is preparation for one's entire life, including professional endeavours and participation in family, society and citizenship, and it never stops – it is a life-span activity. Ideally, professional education ought to develop rules and habits of scholarship so that graduates expect themselves to read, learn, discuss ideas and improve practice.

I have also learned that the literature of many scholarly disciplines outside medicine provides rich support for the significance of occupation and its application in occupational therapy (Yerxa 1998). Perhaps we have been following false leads in searching for support within the ideas and approaches of medicine. That is why it is so important to understand medical thinking (diagnosis and treatment via drugs and surgery) while developing, supporting and transmitting our own way of thinking.

Our detective work with the help of these great minds will allow us to think broadly, beyond technique and mechanistic quick fixes, to help human beings regain control over their lives and environments, to use their time in satisfying ways, to remain well during the ageing process via engagement in occupation and to obtain true equality of capability (Bickenbach 1993).

Searching for new ideas will be stimulated by developing communities of scholars around every academic programme. Clinicians as members of these communities will raise significant questions and puzzles from practice, 'clinical irritations' that need to be addressed with fresh perspectives from the literature. Academics will contribute their scholarship and research and students their curiosity, unrestricted by allegiance to 'common knowledge' (also known as 'old ideas'). These 'detective services' will develop repositories for clues and knowledge that can be used by all their members to solve clinical puzzles and to develop innovative models of practice as well as to modernise and upgrade the curriculum. Communities of scholars from all over the globe will create new visions of an occupational therapy profession which truly meets the needs of the people it serves by increasing their life opportunities. Occupational therapy will be understood and valued both by the public at large for its essential service and in the university environment as an academic discipline respected for its contribution to the universe of knowledge constituting a university.

Doing our detective work will enable our profession to define its practice in a way that actualises our caring, expressing heart by providing our best knowledge-based, reflective, ethical practice. New ideas will remove the fetters of reductionism, freeing our minds to think about the complex occupational human, in his or her environment, developing capability and connecting with culture through the use of hands, mind and will (Reilly 1962).

Osborn (1998) completed her book with a statement reflecting heart and mind:

> I would counsel those with a devastating injury not to focus on their loss and what might have been, but to fully live the life they have now and to carve out new and achievable dreams to fit it (p232).

Occupational therapists, by virtue of our scholarly detective work, can help to shape those new and achievable dreams so that more lives can be lived fully.

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