IF IT AIN'T BROKE, WHY REHABILITATE IT? CANADIAN OCCUPATIONAL THERAPY IN THE REHABILITATION ERA, 1950-1985

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Abstract

An increase in healthcare funding as well as the rehabilitation needs of Canadians enabled an expansion of practicing occupational therapists over the Rehabilitation Era, spanning the 1950s-1980s. Canada saw changes to hospital system funding through the transition to public healthcare, advances in medicine allowing more individuals to live with disabilities, and population growth, among many compounding factors resulting in more Canadians wanting or needing occupational therapy. Coined the "Rehabilitation Era" due to the growth of rehabilitation and a remedial focus in care through the use of the medical model, occupational therapists employed a multi-pronged approach to help meet the demand for their services.

The context of the Rehabilitation Era highlighted and contributed to occupational therapists' challenges in defining what skills lay within, and outside of, their professional boundaries. Occupational therapists' fragile professional identity entering a period of rapid growth led to a variety of new areas of practice. When Canada transitioned to a publicly funded healthcare system, it created a system disturbance for healthcare professionals to redefine their areas of expertise. Due to a combination of occupational therapy's relatively small size, a predominantly female composition, and entering this transition as a role subjugated under physicians, occupational therapy had difficulty fully realizing the opportunities available. Further, due to other professions and the healthcare system more broadly shifting in focus to remediation, occupational therapists found themselves frequently uncomfortable and poorly aligned with predominant models of practice.

Over the course of the Rehabilitation Era, occupational therapy diversified drastically. Factors including gender, power structures, perceived and legitimate control over a knowledge base, and the external understanding of the role, each influenced the trajectory of the profession's evolution. Occupational therapy's absence of societal understanding of the scope of practice, value to the healthcare system, and professional expertise has consistently limited its ability to meet all criteria of professionalism. These challenges were highlighted particularly strongly during the Rehabilitation Era with the rapid changes to the healthcare and education systems. Given occupational therapy's challenges in philosophical alignment with the medical model and the expanding areas of practice facilitated through the Rehabilitation Era, if it wasn't broken, why did occupational therapy choose rehabilitation?

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CAOT	Canadian Association of Occupational Therapists/ Therapy
CMA	Canadian Medical Association
CMOP	Canadian Model of Occupational Performance
COTA	Community Occupational Therapy Associates
CPA	Canadian Paraplegic Association
OPM	Occupational Performance Model
PEO	Person Environment Occupation

Introduction

In her 1966 Presidential address to the CAOT, Thelma Cardwell famously described occupational therapy, stating, "we are too diffident a group, both individually and collectively. We are much too timid in bringing our work to the attention of others. In short, we are ineffective in selling our profession."[1] As the newly minted president, the first female, and the first occupational therapist to hold the role, her address aimed to set the profession on a new path: a path towards confidence and improved external understanding, and a more concrete reputation in healthcare settings. Cardwell went on to state that "… with an added degree of confidence, [we] can do an immeasurable amount in establishing the personal and professional reputation and respect that our profession warrants."[2] However, since giving that address, her call to action has been cited frequently and repeatedly throughout occupational therapy publications, talks, and settings, suggesting that this feeling has not significantly changed amongst occupational therapists.[3] While the funding models in healthcare, occupational therapy's scope of practice, and programs educating occupational therapists have all undergone drastic changes since her address, a core sense of dissatisfaction remained among occupational

[1] Thelma Cardwell, "President's Address." *Canadian Journal of Occupational Therapy* 33, no. 4 (1966): 139. https://doi.org/10.1177/000841746603300401, CAOT had recently changed their name from Canadian Association of Occupational Therapy to Canadian Association of Occupational Therapists in 1961, reflecting the change towards the association focusing more upon the therapists themselves. For their centennial, CAOT will be changing their name back to stand for the Canadian Association of Occupational Therapy.
[2] Cardwell, "President's," 139.
[3] Judith Friedland, "Occupational Therapy and Rehabilitation: An Awkward Alliance." *The American Journal of Occupational Therapy* 52, no. 5 (1998): 373-380. https://doi.org/10.5014/ajot.52.5.373; Cooper, Juliette E. "Reflections on the Professionalization of Occupational Therapy: Time to Put Down the Looking Glass." (2012): 201. https://doi.org/10.2182/cjot.2012.79.4.2; Isobel M. Robinson "Muriel Driver Memorial Lecture 1981: The Mists of Time." *Canadian Journal of Occupational Therapy* 48, no. 4 (October 1981): 145–52; Gary Kielhofner, "The Demise of Diffidence: An Agenda for Occupational Therapy," *Canadian Journal of Occupational Therapy* 52, no. 4 (1985): 165-171. https://doi.org/10.1177/000841748505200401; Marilyn Luella Ernest, "The Changing Role of the Occupational Therapist." PhD diss., University of British Columbia, 1972; James D. Maxwell, "The Queen's University Study of Occupational Therapy Some Reflections and Conclusions." *Canadian Journal of Occupational Therapy* 44, no. 3 (1977): 137-139; Mary Manojlovich, "Look Out the Window and Open the Door." *Canadian Journal of Occupational Therapy* 70, no. 1 (2003): 5-7. https://doi.org/10.1177/000841740307000101; Lynn Cockburn. "Change, Expansion and Reorganization: CAOT in the 1970s." *OT Now* 3 (2001): 3-6.

therapists regarding how the profession is perceived by others. In light of this ongoing feeling of dissatisfaction and a history of attempts to rectify such discomfort, it is relevant to examine the time in which Cardwell gave this address. Frequently referred to as the Rehabilitation Era, spanning 1950-1985, modern occupational therapists are also quick to lament the profession's place in the healthcare system and overall approach to occupational therapy during this era. Cardwell's optimism reflected the significant changes occupational therapy underwent during this period, including expansion of their scope and areas of practice, overall numbers of therapists, and educational expectations. Over the course of the Rehabilitation Era, occupational therapy grew within a healthcare system that was inconsistently congruent with their theoretical approaches, which further entrenched their challenges and dissatisfaction with their professional identity.

History of Canadian Occupational Therapy, 1917-1950

Today, occupational therapists are typical members of healthcare teams in Canada, working across populations and diagnoses to assist patients in participating in acts of daily living.[4] Occupational therapists are particularly concerned with occupations themselves, defined in occupational therapy literature as,

> …groups of activities and tasks of everyday life, named, organized, and given value and meaning by individuals and a culture. Occupations include everything that people do to occupy themselves, including looking after themselves (self-care), enjoying life (leisure), and contributing to the social and economic fabric of their communities.[5]

Here, meaning is critical for occupational therapists, as without meaning a task or activity is not truly an occupation. Of course, this notably contrasts with the lay definition of occupation, being,

[4] Canadian Association of Occupational Therapists. "CAOT Position Statement: Occupations and Health." *Occupational Therapy Now* 11, no. 1 (2008): 24-26.
[5] Canadian Association of Occupational Therapists, "CAOT Position," 24.

"a job or profession."[6] Such a sharp contrast nicely highlights a common and fundamental miscommunication between occupational therapy and the public. Despite being typical members of healthcare teams in hospitals, rehabilitation centres, home care programs, children's treatment centres, workplace insurance boards, mental health settings, and beyond, many Canadians remain unaware or unclear of the role of an occupational therapist.[7] This limited understanding is also reflected by the fact that occupational therapy remains an understudied area within the field of Canadian healthcare history. Whether it is a result of occupational therapists and their poor marketing, as Cardwell contends, remains to be determined.

Occupational therapy is not a new profession, with the first instances of the title being used in 1917.[8] In Canada, the profession of occupational therapy formally entered the healthcare sector during the later years of World War I.[9] Its inception was the evolution of a similar role in

[6] "Occupation." Merriam Webstrer.com. 2011. https://www.merriam.com/dictionary/occupation

[7] Canadian Institute for Health Information. "Occupational Therapists." Data tables, October 14, 2024. Statista. Accessed September 22, 2025. https://www.cihi.ca/en/occupational-therapists#:~:text=11%2C718%20occupational%20therapists%20(OTs)%20were,supply%20was%20younger%20than%2040. Occupational therapy is a mid-sized healthcare profession, with 19,312 registered occupational therapists across Canada practicing in 2020. Compared to the similar profession of physiotherapy, which had 26,019 practicing members in 2020 and has a much higher level of social understanding, the role of occupational therapy is prevalent enough to reasonably assume societal understanding. The profession is also notably larger than other commonly understood professions such as midwives, who had around 1700 practicing in 2019, or nurse practitioner, with 6,661 practicing in 2020. Andrew T. Rogers et. al, "Higher Hospital Spending on Occupational Therapy is Associated with Lower Readmission Rates." *Medical Care Research and Review* 74, no. 6 (2017): 668-686. https://doi.org/10.1177/1077558716666981 Further, there is research demonstrating the positive impact of occupational therapy in reducing hospital re-admission rates, early intervention in children, development of independence post stroke, and in upper extremity function, among other areas.

[8] Judith Friedland. "Why Crafts? Influences on the Development of Occupational Therapy in Canada from 1890 to 1930." *Canadian Journal of Occupational Therapy* 70, no. 4 (2003): 204-212. https://doi.org/10.1177/000841740307000403 ; Norman L. Burnette, "The Status of Occupational Therapy in Canada." *American Journal of Physical Medicine & Rehabilitation* 2, no. 3 (1923): 179-182.

[9] William J. Dunlop, "A Brief History of Occupational Therapy." *Canadian Journal of Occupational Therapy* 1, no. 1 (1933): 6-10, https://doi.org/10.1177/000841743300100102; Muriel F. Driver, "A Philosophic View of the History of Occupational Therapy in Canada." *Canadian Journal of Occupational Therapy* 35, no. 2 (1968): 53-60, https://doi.org/10.1177/000841746803500203; Kathryn Lewis et al. "Looking Back to Move Forward: Canadian Occupational Therapy in Public Health, 1914 - 2019." *Canadian Journal of Occupational Therapy* 88, no. 1 (2021): 48-58, https://doi.org/10.1177/0008417421992617; Sue Baptiste "Occupational Therapy: The Foundations, the Changes, the Future." *Occupational Therapy Now* 13, no. 1 (2011): 3-5.

the late 1890s, who principally used therapeutic arts and crafts.[10] In the early years, occupational therapists aimed to find ways for permanently disabled veterans to earn any type of income after the war, as well as to *divert* their minds from focusing on their injuries or disabilities. The use of the word divert is important here, as the premise behind using crafts had a comparable amount to do with distracting the veteran's minds as it did with benefits of actually completing the work. Many occupational therapists sought to inspire veterans to occupy their time in some way, with notions of working towards improving medical outcomes happening later, in the 1940s. [11]

During the Great Depression, occupational therapists pushed and expanded their role outside of veterans' hospitals, touting the value of participation and meaningful activity for other individuals previously unable to work or occupy their time in a 'productive' fashion.[12] While meeting with some success, the profession remained limited until after World War II.[13] Shortly after, during the period of 1950-1985, occupational therapy underwent significant growth, changes in identity and education, as well as the expansion in their scope of practice. This period is often referred to as the "Rehabilitation Era," because occupational therapy shifted to focus on using the medical model for rehabilitation.[14] Due to the high number of individuals who had been injured and were looking to return to a similar state and/or the most functionally

[10] Friedland. "Why crafts?" 204-212; Judith Friedland, *Restoring the Spirit: The Beginnings of Occupational Therapy in Canada, 1890-1930*, (McGill-Queen's Press, 2011), 85-95; Helene Polatajko, "The Evolution of Our Occupational Perspective: The Journey from Diversion Through Therapeutic Use to Enablement." *Canadian Journal of Occupational Therapy* 68, no. 4 (2001): 203-207. https://doi.org/10.1177/000841740106800401

[11] Friedland, "An Awkward Alliance," 373-380. Modern occupational therapy puts meaning at the centre of all activities occupying one's time, which would largely not encompass activities completed for the sake of distraction. However, the essence of diversional activities remains through the concept of meaningful activities through the idea that activity in and of itself can be therapeutic.

[12] Friedland, *Restoring the Spirit,* 85-130; Driver, "A Philosophic View," 53-60

[13] Cockburn, "Change, Expansion," 3-6; Lynn Cockburn. "The Professional Era: CAOT in the 1950's & 1960's." *OT Now* 3 (2001): 5-9.

[14] Cockburn, "Change, Expansion," 3-6; Cockburn, "The Professional Era," 5-9; Helen P. LeVesconte, "Some Aspects of Rehabilitation in Canada." *Canadian Journal of Occupational Therapy* 22, no. 2 (June 1955): 47-53. https://doi.org/10.1177/000841745502200204 This change in focus reflected a change in the healthcare system and designated roles, rather than a desire for change pushed for by occupational therapists themselves.

independent and productive version of themselves, rehabilitation in this period was heavily focused on using the medical model.[15]

Importance of the "Rehabilitation Era"

Occupational therapy was not alone in its experience of significant growth over the Rehabilitation Era. During this period, the Canadian healthcare system more broadly underwent significant changes, most notably in the transition to publicly funded healthcare. Such a change in the logistics of access and funding for healthcare increased the overall utilization of the Canadian healthcare system. This increase in use occurred simultaneously to notable advances in medical science. The medical model of disability flourished within the context of increased access to healthcare and increased capacity of healthcare services to heal and prevent illness. The prevalence of the medical model during a period of significant reorganization of the Canadian healthcare system had an enduring impact on the methods of healthcare delivery.

The medical model posits that ill health, or disablement, is based on an issue located within the individual's body that can be specifically fixed.[16] Adherents of the model believe that changing the person will change their life outcomes, and that medicine is capable of returning or delivering individuals to a state where they are able to participate in society in a 'typical' fashion. They pay less attention to preventative measures, and, importantly, they give little consideration to the environment and social conditions as they pertain to disability.[17] One implication of the model is that physicians have the most control within the healthcare system, since identifying (i.e. diagnosing) specific ailments is the first step towards healing. Throughout

[15] Sharon Brintnell et. al, "The Rehabilitation Era: Friend or Foe." *Canadian Journal of Occupational Therapy* 53, no. 4 (November 1986): 27–28. https://doi.org/10.1177/000841748605305410
[16] Deborah Marks, "Models of Disability." *Disability and Rehabilitation* 19, no. 3 (1997): 85-91.
[17] Marks, "Models of Disability," 85-91.

the Rehabilitation Era, physicians across a variety of disciplines diagnosed ailments and subsequently prescribed treatment methods, including occupational therapy.

In the years that followed World War II, the federal government provided more funding to meet increased physical and psychiatric medical service needs and, later, to help establish a public healthcare system. Provincial and territorial governments also provided funding to healthcare and directed the federal allotment within their areas. This money often facilitated the development of rehabilitation centres across Canada, as well as increased or began rehabilitation departments within hospital settings.[18] The relatively abrupt increase in services created a high demand for occupational therapists, resulting, in part, in the growth of the profession.[19] These formative years spanning the Rehabilitation Era significantly increased the number of practicing occupational therapists across the country and shaped many of their areas of practice.[20]

Taken together, the demonstrated growth in the impact and size of the profession of occupational therapy within the context of a changing healthcare system should have resulted in a role more commonly understood and one that has warranted historical inquiry. This expectation has not been met, as the role remains relatively unknown and understudied.[21] Examination of the Rehabilitation Era provides an understanding of why the profession followed a trajectory to remain fairly unknown to the general public. Through the following analysis of social and

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[18] Cockburn, "The Professional Era," 5-9; Goldwin W. Howland, "Occupational Therapy Across Canada." *Canadian Journal of Occupational Therapy* 53, no. 4 (1986): 18-26. https://doi.org/10.1177/000841748605305409; Maxwell, "The Queen's University Study of Occupational Therapy," 137-139. Following the culmination of World War II, the federal government was highly motivated to create a different experience for veterans, as compared to World War I.

[19] Cockburn, "The Professional Era," 5-9; Robinson "Muriel Driver Memorial Lecture 1981," 145–52.

[20] Brintnell et. al, "The Rehabilitation Era: Friend or Foe," 27–28. https://doi.org/10.1177/000841748605305410 There is some debate in the literature and among current occupational therapists as to if the rehabilitative period or the initial period of occupational therapy is more similar to the modern practice of occupational therapy. As the rehabilitative period turned away from holistic care to a certain extent, some make the case that rehabilitation is significantly different than holistic and purposeful-driven occupational therapy today. However, the rehabilitative era includes a much more similar scope of practice and job description to occupational therapists practicing today.

[21] Tsing-Yee Emily Chai and Gregor Wolbring. "The Portrayal of Occupational Therapy and Occupational Science in Canadian Newspapers: A Content Analysis." *Societies* 6, no. 2, 18 (2016): 1-21. https://doi.org/10.3390/soc6020018

cultural forces, this work begins to explain the driving factors in the evolution of the profession during this critical period of expansion. The small size and predominantly female makeup of occupational therapy, in combination with physician supervision, frequently acted as constraining factors, and directed the growth of the profession into areas that were not always preferable to occupational therapists themselves. Occupational therapy's position within the healthcare system during the transition to publicly funded healthcare drove the profession along a rehabilitation-focused growth trajectory.

The Rehabilitation Era proved critical to the history of occupational therapy as a profession. Between 1950 and 1985, the educational system producing occupational therapists in Canada grew from a single, diploma program to ten university programs offering an undergraduate degree.[22] This growth included combined occupational therapy and physiotherapy programs, an unrecognized college program, and a condensed 'Special Program,' as CAOT attempted to keep up with the demand for service while maintaining educational standards.[23] In addition to increasing Canadian education programs, many internationally trained occupational therapists moved to Canada during this time period. Subsequently, the number of practicing occupational therapists across the country dramatically increased.[24] With the changes in

[22] Helen Madill and E. Sharon Brintnell. "Occupational Therapy Education in Canada: The Facts and Figures." *British Journal of Occupational Therapy* 42, no. 5 (May 1979): 116–19. https://doi.org/10.1177/030802267904200507 This does not include Mohawk College, which technically graduated occupational therapists, but was not a program that was recognized by CAOT. The program moved to McMaster University in 1984; Cockburn, "The Professional Era," 5-9. CAOT changed its name from the Canadian Association of Occupational Therapy to the Canadian Association of Occupational Therapists in 1963. The educational standard for entry to practice changed to a Master's level for all provinces except for Quebec in the early 2000s.

[23] See Table 1. A note on language- physiotherapy is the title for physiotherapists in Canada today, and has been for much of its history. However, there were instances of it instead being called "physical therapy" (as it is in the United States). For the purposes of this dissertation, "physiotherapy" and "physical therapy" will be used to reflect the source material and are considered interchangeable.

[24] Canadian Institute for Health Information. "Occupational Therapists." Data tables, October 14, 2024. Statista. Accessed September 22, 2025. https://www.cihi.ca/en/occupational-therapists#:~:text=11%2C718%20occupational%20therapists%20(OTs)%20were,supply%20was%20younger%20than%2040.

education and increased presence in hospital systems, the scope of occupational therapy also increased to include a variety of more medically focused goals. Changes in healthcare funding, models of practice, and women's participation in the workforce, in combination with increased advocacy for occupational therapy, the evolution in technology and health knowledge, and competition between healthcare professions all combined to create this rapid growth and changes to practice.

Importantly, the CAOT also evolved during this period. CAOT underwent significant changes in their endeavours to navigate the changing landscape of Canadian healthcare, the growth of the profession, and the expansion of educational programs. A primarily female, volunteer organization for most of this time period, the women dedicated significant portions of their time to try and meet the needs of practicing occupational therapists. Although occasionally more reactive and proactive in approach, CAOT remained a significant player in the development of occupational therapy due to its regulatory status, dissemination of research, and reflection of the priorities of the profession as a whole. CAOT made many significant contributions to the trajectory of occupational therapy through participation in government working groups, accreditation of educational programs, outlining standards as well as goals of practice, providing practice resources, and advocacy, among other endeavours. CAOT made every effort to establish occupational therapy as an autonomous health profession.

Historiography

The most thorough work that has been completed on the history of Canadian occupational therapy is Judith Friedland's *Restoring the Spirit: The Beginnings of Occupational Therapy in Canada, 1890-1930*. Friedland's work has been well-received by Canadian occupational therapists and provides an important overview of the early years of the profession

that preceded the Rehabilitation Era. Friedland examines the roots of the profession in Canada, reminding modern occupational therapists of the similarities between the arts and crafts movement and current approaches to occupational therapy.[25] For Friedland and many other present-day occupational therapists, the roots of the profession lie with the idea that engaging in occupation is beneficial for one's health.

Friedland's selection of a period prior to the expansion of the profession, therefore, is deliberate, as she aims to demonstrate the similarities between occupational therapy in its initial years and in the late 20th and early 21st century. In essays, Friedland presents the Rehabilitation Era as a straying away from the core values of occupational therapists. Friedland argues that aligning with rehabilitation is the root cause for modern identity challenges and the profession must return to the core values established in the early 20th century.[26] Friedland's argument centres around the loss of an occupational focus, as the profession instead focused on physical rehabilitation.[27] She attributes this loss to the appeal and prominence of the medical model that took over in Canadian healthcare during the 1950s, which placed significantly more value upon "fixing" above all else.[28] Writing in the late 1990s, Friedland summarizes the fundamental issue with occupational therapy falling within rehabilitation, as "rehabilitation continues to see

[25] Friedland, *Restoring the Spirit;* Judith Friedland, personal communication with author, January 2020. Modern occupational therapy approaches to mental health include similar thinking patterns as early occupational therapy, focused on developing methods and activities for individuals to return to participation in their lives. Friedland also graduated in occupational therapy when the program was combined with physiotherapy and heavily focused on the medical model, which does not align strongly with occupational therapy approaches to mental health work. Her educational background and experience in the field is clear throughout her work, at times seeming to colour her interpretation of the sources. Friedland's selection of a period prior to the expansion of the profession, therefore, is deliberate, as she aims to demonstrate the similarities between initial and modern occupational therapy. It does mean, however, that she excludes an important period when the profession underwent significant change. Friedland also does not engage very much with wider historical scholarship in numerous areas including the history of women's movements, labour, and health professions.
[26] Friedland, "An Awkward Alliance," 373–80.
[27] Friedland, "An Awkward Alliance," 373–80.
[28] Friedland, "An Awkward Alliance," 373–80. Here, rehabilitation is synonymous with "fixing" due to the medical model and definitions of rehabilitation during this period.

engagement in occupations as a separate and subsequent step."[29] To Friedland and many occupational therapists, rehabilitation is considered the initial "fixing," which precedes participation in meaningful activities. She discusses this focus on fixing in combination with occupational therapy's self-perceived low status within medical hierarchies. The tone of these articles is a combination of disappointment and regret, as Friedland discusses the mistakes she feels the profession made during the Rehabilitation Era.

In "Occupational Therapy and Rehabilitation: An Awkward Alliance" Friedland dedicates the minority of her article to discuss the 1950s-1970s themselves, instead focusing on the earlier years of the profession.[30] As with *Restoring the Spirit*, Friedland does not significantly engage with wider literature to aid in explaining the prominence of the medical model, the rationale behind perceived low status of occupational therapy, or any potential additional factors such as funding bodies.[31] While she is able to provide some evidence as to why physiotherapists became much more prominent than occupational therapists, the work falls short of satisfactorily examining the full rationale of the focus upon rehabilitation methods.[32] Importantly, Friedland also does not dive into the word "curing" employed by a variety of early occupational therapy leaders she references.[33] Curing through means of work was one early goal of occupational therapy, which would appear to be in line, on some level, with rehabilitation goals of curing through specific exercises.

While the argument that rehabilitation separated or reduced participation in occupations is supported by the change in areas of practice over the course of the Rehabilitation Era, such an

[29] Friedland, "An Awkward Alliance," 373.
[30] Friedland, "An Awkward Alliance," 373–80.
[31] Friedland, "An Awkward Alliance," 373–80.
[32] Friedland, "An Awkward Alliance," 373–80.
[33] Friedland, "An Awkward Alliance," 373–80.

argument does not sufficiently account for the external pressures of the healthcare system. Friedland is dismissive of this context, stating,

> The medical model, complete with its uniforms and jargon, gave occupational therapists what was considered a loftier status. Rehabilitation was more respected and better understood than occupational therapy, and it caught the public eye… if we were helping them [persons with disabilities] in such obvious and concrete ways as getting stronger, moving faster, or gaining a fuller range of motion, well, then we must be good too.[34]

Here, Friedland credits occupational therapy's autonomy and voluntary choice in their use of the medical model. While providing context of physicians strongly influencing this decision, her argument nevertheless focused on the choices made on a voluntary basis to improve external understanding and status. However, in the context of a changing health care system, one that was based within the medical model and run by physicians, the expansion of occupational therapy needs to be considered within a structural context. Decisions made by the professions were not entirely voluntary, as they occurred within a specific system, with gendered and professional levels of influence further impacting the choices available to be made.

Importantly, demonstrating the value of one's profession in "obvious and concrete ways" was needed during a period where the healthcare system changed and expanded. During World War II, physicians overserved the physical benefits of participating in occupations. Physical changes, such as improved muscle strength or greater range of motion, is much easier to capture and observe than psychological changes may be. Further, as many disabled individuals had the goal of obtaining employment, physical capacity played a significant role in this pursuit. While the argument that removing the meaning from occupations in occupational therapy was harmful and made job activities incongruent with occupational therapy's core philosophies is valid, it

[34] Friedland, "An Awkward Alliance," 373–80.

does not give sufficient credit to the hierarchies of power within healthcare, nor the influence of medical science.

Other than Friedland's work, there have been more narrow examinations of certain aspects of occupational therapy's history. These include intermittent single article publications on the Rehabilitation Era, published in scholarly journals such as the *Canadian Journal of Occupational Therapy* as well as short pieces in occupational therapy's national newsletter, *OT Now.* There is also a history of occupational therapy in Quebec. Most historical works written on Canadian occupational therapy are conducted primarily for a celebrative purpose and largely are written for and read by occupational therapists themselves.[35] Like Friedland, there are other occupational therapists who look to history to express their concern about the impact of the Rehabilitation Era.

In 1986, four prominent occupational therapists, Sharon Brintnell, Helen Madill, M. Thelma Cardwell, and Isobel M. Robinson, wrote a brief synopsis of the state of occupational therapy in the 1950s and 1960s titled, "The Rehabilitation Era: Friend or Foe." The authors examine publications in the Canadian Journal of Occupational Therapy from 1950-1969 to demonstrate the state of the field during that time. While concluding that rehabilitation was the focus of the period, the authors refrain from taking a firm stance as to the friend or foe status of this time frame.[36] They do, however, comment that occupational therapy withdrew from a holistic approach to practice through the use of the medical model, and that occupational therapy needed to return to a focus on the whole person. The authors cite a short article produced in the 1960s by an occupational therapist to demonstrate the narrowed focus occupational therapists

[35] Cockburn, "Change, Expansion," 3-6; Cockburn, "The Professional Era," 5-9; Barry Trentham, "Diffident No Longer: Building Structures for a Proud Profession." *OT Now* 3 (2001): 3-7; Polatajko, "The Evolution of our Occupational," 203-207; Robinson "Muriel Driver Memorial Lecture 1981," 145–52.
[36] Brintnell et al., "The Rehabilitation Era," 27–28.

placed upon physical factors within disability and how occupational therapists were aiming to rectify those factors. This narrow focus is used as evidence of the predominance of a remedial, medical model approach to occupational therapy, which is in conflict with occupational therapy's holistic roots. While they refrain from taking a firm stance on the merits of the Rehabilitation Era, the authors' position their present day as already having moved beyond the narrow, medical focus, of the Rehabilitation Era. Instead, they argue that in the late 1980s, the profession had returned to holistic care and consideration of the whole person.

Years later in 2001, Helene Polatajko takes a different approach to the history of the rehabilitation era in her article, "The Evolution of our Occupational Perspective: The Journey from Diversion through Therapeutic Use to Enablement."[37] Polatajko is one of the primary authors of the current and accepted definition of occupation within occupational therapy literature centred around meaningful activities.[38] She is therefore focused, in this article, around the transition from *diversional* activities to *purposeful* activities. Differing from Friedland, Polatajko highlights the 1960s and 1970s as a period where the term occupation returned to occupational therapy with a new and more functional definition. Polatajko directly compares definitions used in the 1930s with the 1970s to demonstrate the shift and value of the updated understanding of occupational therapy.[39] The process of "enablement" is critical for Polatajko, which she articulates as a process that can occur in a variety of ways, including methods popular in the rehabilitative and non-rehabilitative eras.[40] Polatajko and colleagues define enablement as a concept in occupational therapy to focus on "empowering clients to achieve their occupational

[37] Polatajko, "The Evolution of our Occupational," 203-207. Polatajko a prominent individual in modern occupational therapy.
[38] Elizabeth Townsend and Helene J. Polatajko. *Enabling Occupation II: Advancing an Occupational Therapy Vision for Health, Well-Being, and Justice Through Occupation.* Ottawa, ON: CAOT Publications ACE. Second edition, 9th Canadian Occupational Therapy Guidelines. (2007), 9-36.
[39] Polatajko, "The Evolution of our Occupational," 203-207.
[40] Polatajko, "The Evolution of our Occupational," 203-207.

potential and engage in meaningful activities that promote health and well-being."[41] While authors such as Friedland argue the rehabilitative period was a step away from early values and holistic care and therefore practices and mentalities originating in that time period should be abandoned, Polatajko instead argues the rehabilitative period provided the impetus for modern occupational therapy, and many of the steps taken should be honed rather than disregarded by practicing occupational therapists.[42]

As is the case with each previously mentioned article, Polatajko's piece is brief and does not examine the wider scholarship or the climate in healthcare at the time. Polatajko's purpose is also evident throughout the article. At the time of publication, she had recently updated the definition of occupational therapy in the Canadian occupational therapy textbook, *Enabling Occupation*, and looked to provide more context in support of her conclusions. Nonetheless, her article highlights how different focal points and interpretations of language used can lead to different analyses around the progress, or lack thereof, made by occupational therapy in the 1950s-1970s.

In the same year as Polatajko's article, Lynn Cockburn published two articles on the history of the CAOT as part of a commemorative series in *OT Now*. Cockburn ties in the broader Canadian medical context more than previous authors, discussing occupational therapists' participation on various committees, funding changes, and the gap in health services that occupational therapists sought to fill.[43] Given that her articles are focused specifically on CAOT, she does not dive deeply into the practice of occupational therapy or the perceptions of most practicing occupational therapists. Cockburn also highlights the increase in practice and

[41] Townsend and Polatajko. *Enabling Occupation II*, 9-10.
[42] Polatajko, "The Evolution of our Occupational," 203-207.
[43] Cockburn, "Change, Expansion," 3-6; Lynn Cockburn. "The Professional Era" *OT Now* 3 (2001): 5-9.

importance of research to the profession, chronicling significant development in the 1960s. Turning to the 1970s, Cockburn considers changes in provincial legislation and the climate of healthcare in Canada, as well as the pursuit of independence from physiotherapy. According to Cockburn, much of the 1970s seemed to focus upon charting a new path for occupational therapy, one focused on growth as an autonomous profession.[44]

While Cockburn's two articles focus explicitly on the Rehabilitation Era and begin to draw in other contextual considerations, the articles also follow similar themes as previous works. Her two pieces are brief and were completed as part of a 70th anniversary celebration of CAOT. Not surprisingly, Cockburn paints a history of progress and does not engage much with any potential setbacks, be they perceived or legitimate. Given that the early 2000s was a period of increased access and use of technology in healthcare, the historical series published by CAOT is heavily focused on being able to demonstrate how occupational therapists have flourished through change, with the implied message that they would continue to do so in the new technological era.[45]

Francine Ferland and Élisabeth Dutil chronical the history of occupational therapy in Quebec in their monograph *Histoire de l'ergothérapie au Québec: histoire d'une profession.* Ferland and Dutil aim to tell the story of occupational therapy in Quebec, stating (translated),

> This book is intended primarily for young occupational therapists, so that they can learn about their predecessors, the milestones of their profession, and its historical background.[46]

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[44] Cockburn, "Change, Expansion," 3-6.
[45] Lili Lui, "Occupational Therapy in the Fourth Industrial Revolution." *Canadian Journal of Occupational Therapy* 85, no. 4 (2018): 272-283. https://doi.org/10.1177/0008417418815179; Alison Lall, Jennifer Klein, and G. Ted Brown. "Changing Times: Trials and Tribulations of The Move to Master's Entry-Level Education in Canada." *Canadian Journal of Occupational Therapy* 70, no. 3 (2003): 152-162. https://doi.org/10.1177/000841740307000304
[46] Francine Ferland and Élisabeth Dutil. *L'Ergothérapie au Québec: histoire d'une profession*. Montréal (Québec), Canada: Presses de l'Université de Montréal, 2012, 11. Original text: Ce livre, nous le destinons surtout aux jeunes ergothérapeutes, pour qu'ils sachent ce qui les a précédés, pour qu'ils connaissent les faits marquants de leur profession, pour qu'ils en aient une culture historique.

As practicing occupational therapists, each with over forty years of experience, Ferland and Dutil are similar to Friedland in that they are telling the history of occupational therapy for occupational therapists.[47] Their narrower scope of interest allows the study of occupational therapy in Quebec from the 1960s until the early 2000s. Rather than employing traditional historical methods, such as drawing upon archival work, Ferland and Dutil employ qualitative methods to investigate the history of occupational therapy in Quebec. Through interviews and surveys, Ferland and Dutil tell a more personal history of Quebec and its evolution. While *Histoire de l'ergothérapie au Québec* discusses the history of the profession, it does so from a specific, more personalized lens.[48] Ferland and Dutil's approach enables them to achieve their outlined goal, but do not engage specifically in historical scholarship and have highly limited generalizability beyond Quebec.

A notable exception to the trend of occupational therapists writing for an occupational therapy audience is Julien Prud'Homme. Prud'Homme has written a dedicated article to occupational therapy, a 2011 article titled, "What is a "Health" Professional? The Changing Relationship of Occupational Therapists and Social Workers to Therapy and Healthcare in Quebec, 1940-1985." In addition to this article, Prud'Homme, had written several other chapters and articles on allied healthcare professionals, particularly regarding the timing around Medicare. In his 2011 article, Prud'Homme compares the professional trajectories of Quebec's occupational therapists and hospital social workers to demonstrate how professions transitioned from non-institutional positions to become firmly located within hospitals through carving out

[47] Ferland and Dutil, *L'Ergothérapie au Québec,* 11.
[48] Ferland and Dutil, *L'Ergothérapie au Québec.*

new roles for themselves within the expanding institutional healthcare system.[49] He demonstrates the evolution of occupational therapy thoroughly, although the experience in Quebec cannot necessarily be extrapolated to the rest of Canada due to the province's different healthcare and education systems. Prud'Homme examines how the external context of new boundaries in Quebec healthcare shaped the development of occupational therapy, with his work demonstrating how fundamentally valuable the historical context is in illuminating professional trajectories.

In his chapter with Antoine Rossignol in *Medicare's Histories: Origins, Omissions, and Opportunities,* titled "From Health-Care Policy to Professional Politics: Medicare and Allied Health Professionals in Quebec, 1960-90" occupational therapy is used as one example to illustrate how allied health professionals interacted with the structural opportunities presented with Medicare. Prud'Homme and Rossignol demonstrate the relationship between professional identity, opportunities, political mobilization, medicalization, and public policy, among other intersecting forces shaping allied health professionals in Medicare. The authors highlight the complexity of occupational therapists and other allied health professions experienced more clinical freedom due to and increased population base entering the hospital and physician's reduced ability to closely supervise practice against a backdrop of constrained structural opportunities.[50] Due to these structural constraints, Prud'Homme and Rossignol consider allied health professional's participation in private markets. This expansion into private markets, which Prud'Homme explores more specifically in his article "Professionnelles des soins et marchés de la santé: les trajectoires analogues des physiothérapeutes et des psychologues québécoises, 1950-

[49] Julien Prud'Homme, "What is a "Health" Professional? The Changing Relationship of Occupational Therapists and Social Workers to Therapy and Healthcare in Quebec, 1940–1985." *Canadian Bulletin of Medical History* 28, no. 1 (2011): 71-94. https://doi.org/10.3138/cbmh.28.1.71

[50] Julien Prud'homme and Antoine Rossignol. "From Healthcare Policy to Professional Politics: Medicare and Allied Health Professionals in Quebec, 1960-1990." In *Medicare's Histories: Origins, Omissions, and Opportunities,* edited by Esyllt Jones, James Hanley and Delia Gavrus., University of Manitoba Press, 2022: 266-285.

2010" was more successful amongst physiotherapists and psychologists.[51] The expansion into private markets, and the fluidity for some allied health professionals between public and private sectors demonstrate how professional identity and the domain of expertise influenced locations of practice. However, in these discussions of professional expertise, Prud'Homme and Rossignol did not focus on occupational therapy, instead considering professions with greater success in navigating the private market and the public's understanding of expertise.

While these articles have begun the historical examination of Canadian occupational therapy beyond the period covered by *Restoring the Spirit*, they are again predominantly written for an audience of occupational therapists and often engage with historical scholarship from other fields even less than Friedland. This leaves a notable gap in the examination of occupational therapy history in the context of the larger history and healthcare setting. Through consideration of the broader healthcare system, this work provides a more comprehensive history of occupational therapy and fills the present gap.

Theoretical Lenses

To examine the Rehabilitation Era, this work is informed by historical scholarship on professionalization, gender, and the construction of citizenship. The formation of professional identity, influenced by internal and external forces, has been top of mind for occupational therapists for decades, as is highlighted by Thelma Cardwell's comment on the diffidence of the profession. As a profession predominantly composed of women, gendered forces are crucial in understanding professional identity and decision making. As similarly gendered healthcare professions such as nursing have demonstrated, gendered considerations add nuance and

[51] Julien Prud'homme. "Professionnelles des soins et marchés de la santé: Les trajectoires analogues des physiothérapeutes et des psychologues québécoises, 1950-2010." *Revue d'histoire de l'Amérique française* 62, no. 2 (2008): 253-287.

improved understanding in the professional history. In contrast to the lenses of professionalism and gender, which look at occupational therapy itself, citizenship considerations inform the broader historical context of who could participate in occupational therapy. Definitions of citizenship underpin government funding allocations, in part determining the population and goals of occupational therapy. Citizenship captures the population seeking to participate in occupational therapy, as their agency also influenced the evolution of occupational therapy.

While Cardwell was one of the first occupational therapists to name professional identity specifically, many others highlighted this challenge in the years following her 1966 address. The Muriel Driver Memorial Lecture, a lecture awarded by CAOT to individuals who have made or are making an "outstanding contribution to the body of knowledge of occupational therapy" highlights how focused occupational therapists have been on professionalism.[52] In the 1975 inaugural Muriel Driver lecture, Joy Bassett used her time to discuss where occupational therapists, as a profession, stood within the healthcare system, as well as to "rekindle our flagging and battered enthusiasm for the profession."[53] The following year, Margaret Hood looked to "inspire in every practising therapist the urge to go beyond mere competence and aim at excellence in our individual areas of expertise."[54] Barbara O'Shea followed the trend in 1977,

[52] CAOT. "Muriel Driver Memorial Lectureship Award." Accessed September 13, 2025. https://caot.ca/site/about/awards/murieldrivernomination Full criteria as follows:

1. Nominees shall be individual or life members of the Canadian Association of Occupational Therapists.
2. Nominees shall be making, or have made an outstanding contribution to the body of knowledge of occupational therapy.
3. Nominees shall have provided opportunity for members of the profession to benefit from these contributions through publication, presentations or both.
4. Nominees must not be a current Board member or employee of the Canadian Association of Occupational Therapists.
5. Nominees need not be a resident in Canada if the achievements for which they are nominated have relevance to Canadian occupational therapy and they meet the other criteria for the award.

[53] Joy Bassett, "Muriel Driver Memorial Lecture Presented at the 45th Annual Conference of the Canadian Association of Occupational Therapists, June 5, 1975." *Canadian Journal of Occupational Therapy* 42, no. 3 (1975): 91. https://doi.org/10.1177/000841747504200303

[54] Margaret R. Hood, "Muriel Driver Memorial Lecture." *Canadian Journal of Occupational Therapy* 43, no. 3 (1976): 111.

urging occupational therapists to "assess their own projection of occupational therapy to those around them and to become protagonists in effecting a positive professional image."[55] O'Shea's lecture, titled, *Pawn or Protagonist: Interactional Perspective of Professional Identity* had clear ties to Cardwell's earlier discussion of diffidence, as O'Shea argued that "occupational therapists have tended to accept the professional image fashioned by others."[56] In subsequent years, lectures focused on the lack of confidence occupational therapists have in managerial positions, in successful role negotiation, and in consistently and succinctly summarizing the role of occupational therapy.[57]

In addition to the Muriel Driver Lectures, other representative publications of the profession speak to the concerns around professional identity. The *Maxwell Report* was commissioned by CAOT in 1977 to understand the state of occupational therapy from the perspective of occupational therapists. It is officially titled "Occupational Therapy: The Diffident Profession."[58] The report had several key recommendations concerning professional considerations and caused significant discussion among occupational therapists in the years following its publication.[59]

There is ample evidence that occupational therapists were concerned with professional identity and found it to be a consistent challenge in the profession's growth. Occupational therapists seemed to be preoccupied with internal constructs of professionalism, looking to

[55] Barbara J. O'Shea, "Muriel Driver Memorial Lecture: Pawn or Protagonist: Interactional Perspective of Professional Identity." *Canadian Journal of Occupational Therapy* 44, no. 3 (1977): 101. https://doi.org/10.1177/000841747704400303
[56] O'Shea, "Muriel Driver," 101.
[57] Gail B. Gilewich, "Muriel Driver Memorial Lecture: Managers in Occupational Therapy." *Canadian Journal of Occupational Therapy* 46, no. 4 (1979): 131-137; Elizabeth B. Bell, "Muriel Driver Memorial Lecture 1980-Directions for the Decade." *Canadian Journal of Occupational Therapy* 47, no. 4 (1980): 147-153; Mary Judd, "Muriel Driver Memorial Lecture 1982." *Canadian Journal of Occupational Therapy 49*, no. 4 (1982): 117-124.
[58] J.D. Maxwell & M.P. Maxwell, (1977). "Occupational Therapy: The Diffident Profession. The Final Report of the Queen's University Study of Occupational Therapy." Miscellaneous, CAOT Archives, CAOT Head Office.
[59] Maxwell & Maxwell, "Occupational Therapy: The Diffident Profession,"145-146.

change themselves to have a cascading impact of changing perceptions. When considering of the history, it is relevant to examine the concept of professional boundary negotiation in explaining the growth and constraints for the profession.

Earlier definitions of professions and professionalism adopted a functionalist perspective. They outlined the characteristics of a professional, including skills and training, and emphasized the altruistic, ethical, and service orientation that protected the community and justified the social rewards received by individuals engaged in the profession.[60] Other scholars soon criticized the functionalists for not considering power dynamics. These scholars often focused on "social closure," the strategies adopted to gain and maintain exclusive knowledge and social status.[61]

One social closure analysis that is widely employed in considerations of professionalism in the health care system is that of Andrew Abbott. While some analyses tend to focus on the development of a particular profession, his 1988 study importantly considers the larger system. He is interested in and emphasizes the importance of competition among professions for jurisdiction.[62] Abbott helpfully focuses on "system disturbances", where a significant event or change creates a new opportunity for conflict and subsequent boundary negotiation between professions.[63] Health care scholars find Abbott's focus on competition and conflict among

[60] Elizabeth M. Smyth, 1999. *Challenging Professions: Historical and Contemporary Perspectives on Women's Work*. Toronto: University of Toronto Press.
[61] Teena J. Clouston and Steven W Whitcombe. 2008. "The Professionalization of Occupational Therapy: A Continuing Challenge." *British Journal of Occupational Therapy* 71 (8): 314–20. https://doi.org/10.1177/030802260807100802
[62] Lorna De Witt and Jenny Ploeg. "Critical Analysis of the Evolution of a Canadian Nurse Practitioner Role." *Canadian Journal of Nursing Research Archive* (2005): 117; Andrew Abbott, The System of Professions: An Essay on the Division of Expert Labor. Chicago: University of Chicago Press, 1988.
[63] De Witt and Ploeg, "Critical Analysis of the Evolution," 119.

professions within a larger system to be particularly appropriate because it recognizes the situational dynamic of healthcare systems.[64]

The later work of Eliot Freidson goes even further than Abbott in thinking about the larger system, attending to the wider social context in which professionals operate. In his important 2001 work, Freidson presented professionalism as an ideology for organizing and controlling work which competed with two other ideologies, consumerism, and managerialism. Professionalism, in Freidson's view, is perpetually at odds with consumerism and managerialism, both of which have the potential to challenge and "limit the amount of control that occupations have over the work that they do."[65] Together, the approaches of Abbott and Freidson are helpful in directing scholars to consider the wider contexts in which professions develop, whether in terms of the different actors within the health care system, or the wider ideologies shaping the organization and control over work within that system.

In the case of professionalization of Canadian occupational therapy, Juliette Cooper highlights key events in occupational therapy's development, explicitly focusing on the role of societal understanding in the process of professionalization.[66] She argues that professionalization and professional identity have been an iterative process between occupational therapists and

[64] Julien Prud'homme, Tracey L. Adams, and Jean-Luc Bédard "Professional Regulation and Change in Times of Crisis: Differering Opportunities Within and Across Ecologies." *Professions and Professionalism* 14, no. 1 (2024): 1-21. https://doi.org/10.7577/pp.5555

[65] Eliot Freidson, *Professionalism, the Third Logic: On the Practice of Knowledge*. University of Chicago Press, 2001, 108-115 Freidson defines the ideology of managerialism "those who perform executive and management functions in both political and economic institutions exercise specialized skills of a more general sort than subordinates doing the productive work, and while they lack the particular knowledge, skill, and experience to perform that work they claim competence to command." In this ideology, specialized knowledge "must serve rather than command." He defines the ideology of consumerism as assuming that "workers are motivated primarily by their desire to maximize their income." Furthermore, a key characteristic of consumerism is that, in a free market, "individual consumers who cannot themselves perform the work that produces the goods and services they desire nonetheless claim competence to choose to perform work for them, determine what tasks they will perform, and judge the results." Both managerialism and consumerism are therefore in direct opposition, ideologically, with professionalism due to disagreement over capacity to judge work that one could not themselves perform.

[66] Cooper, "Reflections on the Professionalization," 201.

Canadians, with frequent barriers to communication.[67] Cooper is speaking to the necessity of demonstrating professional knowledge outside of the profession itself, and contends that occupational therapists' failure to communicate with the greater public has left it vulnerable to challenges from consumerism and managerialism, and unable to increase professional legitimacy. While clearly writing to advocate for greater outward communication, Cooper's analysis connects the issue of professionalization to the limited social awareness of occupational therapy. The issue of limited social awareness is one that occupational therapists have regularly highlighted, suggesting acknowledgement of an issue especially with regard to occupational therapy's relationship with consumerism.[68]

Another important work that touches on the professionalization of allied healthcare workers, including occupational therapists, is Glenn Gritzer and Arnold Arluke's 1989 book, *The Making of Rehabilitation: A Political Economy of Medical Specialization, 1890-1980.* The authors examine how the expansion of knowledge and changes in technology can be harnessed to justify a speciality status and therefore dominance over a given area of labour.[69] In their view, advances in knowledge and technology do not naturally lead to specialization and professionalization; rather these advances are mobilized by different actors to secure greater control over their work and workplace. Like Abbott, Gritzer and Arluke are interested in the conflicts over occupational boundaries, and therefore chose to examine rehabilitation medicine, where a wide array of professionals participate and compete for power and control. Gritzer and Arluke demonstrate that each member of the rehabilitation field, including professions such as

[67] Cooper, "Reflections on the Professionalization," 201.
[68] Donna Dion, Interview by Katie Lewis. September 12, 2023; Brenda Harper, Interview by Katie Lewis. August 18, 2023, Audrey Inkstater, Interview by Katie Lewis. July 26, 2023; Mary McNamara, Interview by Katie Lewis. August 25, 2023.
[69] Glenn Gritzer and Arnold Arluke. *The Making of Rehabilitation: A Political Economy of Medical Specialization, 1890-1980*. Vol. 15. University of California Press, 1989: 7

physiatrists, physiotherapists, occupational therapists, nurses, and social workers, have all felt a sense of threat or attack when it comes to occupational boundaries and professional autonomy.[70] While the approach of Gritzer and Arluke is helpful in understanding the changes to occupational therapy's scope of practice, the sentiment is shared by different professionals spanning various levels, suggesting experiencing challenges of professional identity within healthcare are not limited to occupational therapists.

While the history of professionalization is important in understanding the development of occupational therapy, another important lens to employ is that of gender. Occupational therapy is a profession that has always been dominated by women. The intersections between challenges of professional identity and medical hierarchies with gendered features of labour and employment are important in understanding the development of allied health professions, including occupational therapy.[71] While no occupational therapy-focused work examines the role of gender at length in the Canadian context, historical scholars have considered the role of gender in the development of allied healthcare professions more broadly.

The majority of works on gender in healthcare focus on nursing history.[72] This is due, in large part, to nursing being the most prominent healthcare profession deemed to be "women's work."[73] In her study of nurses in Vancouver and Calgary between the 1950s and 1970s, Margaret Scaia argues that the caring and nurturing overtones of nursing facilitated an increased presence of women in healthcare. Scaia also argues that nursing education and employment

[70] Gritzer and Arluke. *The Making of Rehabilitation,* 12
[71] Dianne Dodd and Deborah Gorham, *Caring and Curing: Historical Perspectives on Women and Healing in Canada*. University of Ottawa Press, 1994; Gelya Frank, "Opening Feminist Histories of Occupational Therapy." *American Journal of Occupational Therapy* 46, no. 11 (1992): 989-999.
[72] Prud'Homme, "What is a "Health" Professional?" 89-90.
[73] Geertje Boschma, Olive Yonge, and Lorraine Mychajlunow. "Gender and Professional Identity in Psychiatric Nursing Practice in Alberta, Canada, 1930–75." *Nursing Inquiry* 12, no. 4 (2005): 244. https://doi.org/10.1111/j.1440-1800.2005.00287.x

provided important opportunities for women that transcended gender limitations at the time. Although there were notable professional benefits, Scaia emphasizes that nursing posed challenges for mothers attempting to balance work and domestic roles, and that nurses as a profession were underpaid for numerous reasons including gender discrimination and assumptions of women belonging within the home.[74] Her work on nursing provides preliminary evidence for the tensions in gendered expectations across Canada in the postwar period, while also highlighting the gendered factors that constrained and enabled women in nursing.

If Scaia contends that nursing offered women limited but important opportunities, Kathryn McPherson's history of nursing emphasizes that advances were often paradoxical, with certain regressions in views of "women's work."[75] She questions whether the period from the 1940s to 1980s, which included reduction of dependence on student-work, stricter guidelines for private nursing, and increased professional recognition, unequivocally meant progress for the field.[76] Throughout her history of nursing in the twentieth-century, McPherson contends that the unique combination of preconceived gender roles and proletarianization led to ongoing challenges for nurses. While McPherson considers how these same forces shaped the experience of male nurses and orderlies, her analysis can usefully be applied to other positions in hospitals and healthcare systems, including occupational therapists.[77]

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[74] Margaret Scaia. "Becoming a Nurse, Vancouver and Calgary: Women, Work, Motherhood, 1958 to 1976." *BC Studies: The British Columbian Quarterly* 194 (2017): 115.
[75] Kathryn M. McPherson. *Bedside Matters: The Transformation of Canadian Nursing, 1900-1990*. University of Toronto Press, 2003.
[76] McPherson. *Bedside Matters*.
[77] The existence of the term "allied healthcare" captures the deeply ingrained hierarchies present in hospitals and healthcare beyond simply doctors and nurses. By grouping a variety of unique professionals into one single umbrella of "allied health" and often treating these professions as one single group, there is a disregard for the individual contributions, and arguably more importantly expertise, of each role. Prud'homme and Rossignol. "From Healthcare Policy to Professional Politics," 265-266. Prud'Homme and Rossignol argue that nursing history can be valuable to apply to occupational therapy in regard to a gendered analysis before Medicare but not after. Prud'Homme and Rossignol argue that allied health professionals moved away from nursing with the advent of Medicare due to self-regulation privileges. "These "allied health professions" moved away from nursing by explicitly rejecting the care-based ideal and by pursuing a more medical model of professionalization based upon the ability to evaluate patients

Finally, the construction of citizenship is of utmost importance in understanding the development of any health discipline. Socially accepted definitions of citizenship, which have consistently changed over time, inform healthcare decisions. The healthcare initiatives that receive funding, the goals of rehabilitation and like healthcare fields, and focal points in the journey to health are each strongly impacted by citizenship. How society defines a citizen outlines the characteristics that individuals should strive for, thus shaping healthcare goals. Rehabilitation, including occupational therapy, is especially impacted by changes to concepts of citizenship, as the changes expanded who was deemed worthy or able to be receptive to rehabilitation efforts, as well as what the end goal of rehabilitation should be.[78]

Leading up to and during the 1950s, Canadian society strongly valued the economic productivity of its citizens, such that those who could not contribute to the economy were often not considered 'full citizens' in a social understanding.[79] Due to this concept, occupational therapists often worked to support disabled individuals to find or obtain methods of economic contribution. Contributing to the economy enabled individuals to be productive and independent, and therefore citizens. By the 1950s, it was an expectation that medicine and rehabilitation, would be able to return most individuals to previously held economic positions. This expectation, in turn, led to a focus on remediation in rehabilitation.

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and to manage their own patient bases." Therefore, gendered nursing histories must be used with caution in applying like experiences to occupational therapy. As regulation came earlier to Quebec than other provinces in Canada, their argument is most clear with Quebec.

[78] Joanna K. Fadyl, Gail Teachman & Yani Hamdani. "Problematizing 'productive citizenship' within rehabilitation services: insights from three studies." *Disability and Rehabilitation*, Vol 42, no. 20 (2020), 2959-2966. https://doi.org/10.1080/09638288.2019.1573935 By "receptive to rehabilitation" I mean that the individual had a condition that was within medical science's ability to "fix" at that time. As medical science improved, more individuals had conditions that were receptive to rehabilitation or were able to survive more significant events.

[79] Karen Whalley Hammel, "Disability, Rehabilitation and Liminality" In *Perspectives on Disability & Rehabilitation*. 109-124. Churchill Livingstone, 2006. https://doi.org/10.1016/B978-044310059-8.50009-8. That is not to say this value has ebbed drastically in modern day society.

During the late 1920s, 1930s and early 1940s, occupational therapists were looking to continue to work as their number of veteran patients dwindled. Many began to work with individuals, as identified by nurses, who were dependant on family members and/or institutional services but had the potential to complete some form of occupation. Occupational therapists assessed these individuals and then supported them in finding and completing activities within their skill set.[80] Occupational therapists also assessed how they could adapt activities to match the individual's physical capacity. For example, for individuals who could weave but were bed-ridden, occupational therapists developed adaptive looms that fit over a bed so that clients could produce goods from their beds. Less frequently, but on occasion, occupational therapists also provided exercises or activities to practice building capacity in certain physical areas to complete an activity.[81] These occupational therapists often saw patients who were participating minimally in their life and were dependant on others financially as well as practically. Occupational therapy reduced this dependence, in turn providing meaning to the individual's' life.

In the 1950s, this thinking was essentially reversed with changes in medical science and the most common types of patients seeking healthcare and rehabilitation. Strengthening and fixing someone's ailments was the first priority, and if that was deemed impossible due to the nature of the disability, then adaptation was explored. These two philosophies are referred to as top-down and bottom-up approaches. Top-down looks at the activity or occupation an individual wishes to participate in, and subsequently works from there in finding ways to support the client's participation. A bottom-up approach looks at the physical requirements of an activity and

[80] Howland, "Occupational Therapy Across Canada," 18-26. Such an overview is a generalization of the diversity that existed within practice; however, it does capture the much more specific scope of practice for occupational therapists at this time.
[81] An example would be practicing pinching with clothes pins, so that an individual could have the finger strength to hold a pen and write.

builds capacity in those areas to then transfer into participation in an activity. From a modern perspective, bottom-up aligns more with physiotherapy, while top-down with occupational therapy. A bottom-up philosophy is grounded in the medical model of thought, partially explaining why it was popular in this time period.[82]

The goals of a provincial or federal health program often reflect the priorities that the state has for its citizens. Typically, during the Rehabilitation Era, health care services were focused on promoting "productive citizenship ideals," with a heavy focus upon return to work.[83] When citizens returned to work after illness or injury, there was a clear metric of success inherently provided. In the context of the 1950s, when Canada had a significant number of veterans looking to return to or begin some form of paid employment, there was a clear emphasis on this productive understanding of citizenship.[84] These types of rehabilitation more explicitly focused upon returning to work and returning to the individual's previous type of employment.

There is also the question of how the title of occupational therapist interacts with understandings of citizenship. For the lay person, and even for some within healthcare, the term "occupation" has distinct ties to paid employment. Throughout the profession's history, paid work played a significant role in rationale for a referral to, or participation in occupational therapy.[85] With such a clear tie to employment, it is easy to see how occupational therapy could fit within a productive understanding of citizenship, which in turn fits well with remedial rehabilitation. The surface-level relationship of tying the occupation in occupational therapy to

[82] Nestor A. Bayona et. al, "The Role of Task-Specific Training in Rehabilitation Therapies." *Topics in Stroke Rehabilitation* 12, no. 3 (2005): 58-65.
[83] Geertje Boschma et. al, "Citizenship Theory and Health Practices: Creative Work in Care and Rehabilitation." *BC Studies: The British Columbian Quarterly* 202 (2019): 9-20.
[84] Dunlop, *The Rehabilitation Needs,* 1947. The second leading area of rehabilitation, behind veterans' hospitals, was funded by the workplace insurance board.
[85] This trend is observed to a lesser degree in paediatric settings, although "occupation" is often understood to be attending school for children.

paid work, may have had cascading impacts into understandings by consumers and managers of the role for occupational therapy.

A particularly clear example of how occupational therapy fit nicely within a productive understanding of citizenship is the CPA's approach to rehabilitation. The CPA formed in 1944 as an organization created by paraplegic individuals, for paraplegic individuals. The CPA is one of the first major disability organizations that was created by the impacted group, rather than others on behalf of those individuals.[86] The CPA supported rehabilitation efforts, both practically and from an advocacy perspective, and reported rehabilitation statistics, as well as general priorities, in their annual reports. One of the most significant themes spanning their annual reports during the 1950s is that of employment. Employment is spoken about in a way that deems it akin to independence.

In their 1955 report, the Quebec division stated,

> …in this 10th year of our association, we are pleased to report real progress toward the solution of our most serious problem, namely, the useful employment of our people once they have been physically rehabilitated.[87]

The focus on the productive component of citizenship is clear. Language such as "useful" implies that to be considered a full citizen, one must contribute to the economy or to their community. To be independent is to not be dependent on others financially. The CPA was a prominent disability organization, and their priorities speak, to a certain extent, of some of the major goals of disabled Canadians.

The CPA's focus on independent participation in work highlights the goals of many disabled Canadians in the post-war era. While these goals became more visible during the

[86] Mary Tremblay, "The Canadian Revolution in the Management of Spinal Cord Injury." *Canadian Bulletin of Medical History* 12, no. 1 (1995): 125-155. This change of having individuals with disabilities represent themselves also speaks to the trend in disability history of increased capacity of individuals with disabilities.
[87] "Quebec Division," Annual Report of the Quebec Division of the Canadian Paraplegic Association, 1955, 18.

disability rights movement in later decades, economic independence was an important pillar for many. Being employed and able to financially provide for oneself was therefore an important goal in which occupational therapists supported throughout the Rehabilitation Era.

Taken together, the lenses of professionalism, gender, and citizenship aid in illuminating the decision-making processes of Canadian occupational therapists. Many of the previous works completed have focused upon occupational therapy itself, with limited engagement with the broader historical context. This work draws upon the above theories to consider the setting in which occupational therapists and the profession as a whole acted, as well as was acted upon. This enables a more complete picture of the driving and constraining forces involved with the expansion of the profession to be made clear.

Methods

This analysis is shaped by the following questions: 1) To what extent did the medical model play in the expansion of occupational therapy, and how did practicing occupational therapists feel about the inclusion of this model? 2) Why did occupational therapy feel the need to focus upon the medical model and what impact did that inclusion have upon its role in larger systems? 3) How important were gendered forces in driving decisions made by occupational therapy as a profession, and how did gender play a role in perception of status and worth? 4) Why has occupational therapy had such significant challenges with forming a coherent identity? 5) How were relationships with management and consumers of healthcare navigated during the Rehabilitation Era?

To answer the above questions, this work draws upon a synthesis of archival research and oral history interviews. Archival sources were based in the provinces of Alberta, British Columbia, Ontario, and Quebec, in locations including universities, hospitals, and provincial/

national archives. These provinces represent the areas of most educational programs that existed during the Rehabilitation Era, with the exception of the University of Manitoba, which enabled specific examination while remaining a feasible amount of archival research.[88] National sources were used to support a broader perspective and illustrate areas not captured in provincial sources. Oral history interviews are worthwhile due to the significant amount of information and context they provide to the historical record. This study draws upon forty oral history interviews, with occupational therapists who practiced or were educated in Canada before 1985.[89] Occupational therapists are often lumped into "rehabilitation professionals," "allied health," or "other" in many hospital records. There are also instances of the history being lost or not deemed valuable enough to retain a full record.[90] Therefore, utilizing oral history interviews provides opportunity to fill in holes on the history record, or clarify occupational therapy's role within the larger group. Oral history interviews are typically quoted directly within this work, except for the instances of thematic analysis.

In conducting and drawing upon oral history interviews, this work uses narrative theory. Oral history work cannot truly be objective, and this work does not aim to be, instead framing the past as "simply a construction, shaped by the way it is told."[91] Through the use of narrative theory, this work considers both the factual information obtained from the interviews, as well as the narrator's attitudes, feelings, and beliefs about the events discussed. Further, these interviews

[88] Territories were not specifically examined due to the absence of educational programs located within the territories as well as the modern absence of regulation. Oral histories from individuals who worked in the territories was included.
[89] Inclusion and exclusion criteria for recruitment is included in Table 2.
[90] Barry Trentham, "The Value of Oral Histories to the Occupational Therapy Profession." *Occupational Therapy Now* 13, no. 1 (2011): 14-16. There were numerous archives that theoretically should have a rich history of occupational therapy sources, due to the known history of occupational therapists working within the setting, that did not have any archival sources or their sources were missing. For example, the Alberta Health Services Archives had one picture of an occupational therapist, and no other sources, despite occupational therapists working in Alberta hospitals for the entire duration of the Rehabilitation Era.
[91] Donald A. Ritchie, *Doing Oral History*. Oxford: Oxford University Press, 2015, 124.

focus on the similarities among a variety of different stories. As Donald Ritchie suggests in *Doing Oral History* "memories people retain are shaped by their cultural values and environment, reflecting a society's collective memory."[92] The consideration of the factual material with the cultural values and environment informs the understanding that while occupational therapy expanded within remedial settings over the course of the Rehabilitation Era, occupational therapists themselves were often uncomfortable with these approaches. Occupational therapists often acted in accordance with their own values, even if these values were incongruent with the larger healthcare setting. Thus, occupational therapy's collective memory of the Rehabilitation Era is different from the factual details alone.

My positionality as a practicing occupational therapist has shaped how I approached the oral history component of my dissertation in particular. Working within a children's hospital, I am frequently exposed to and working with medical model, remedial schools of thought. My current position was created through the Rehabilitation Era changes, thus influencing how I feel about occupational therapy's history and present approaches. Further, I have a deep connection to this topic as I am a member of the group in which I study. Many of the oral history interviewees I had met previously, in academic or professional capacities, or I had mutual connections with the individual. This dynamic typically created a comradery in the interview process, though it may have created other dynamics as well. I recognize that my positionality of being within the community may influence my interpretation of the oral history interviews and other sources, but I have consciously worked to mitigate influence by engaging in reflexive practice.

Overview

[92] Ritchie, *Doing Oral History*, 124.

This study is broken up into four chapters, each focusing on a pillar in the development of the profession. *Legislation and Funding* unpacks the larger context in which occupational therapy was situated over the course of the Rehabilitation Era. The changes to the delivery of healthcare services across Canada resulted in most opportunities for occupational therapy employment located within a hospital setting. Legalisation that led to funding changes provided many opportunities for growth, which occupational therapy realized, but came at the cost of theoretical alignment with the roots of occupational therapy philosophy. *The Challenges for Occupational Therapy in Rehabilitation* examines this philosophical incongruency specifically, looking at how occupational therapists operated on individual levels to practice in a way that was congruent to their education and their theories of practice. While understandings of citizenship informed who was funded to participate in occupational therapy services, disability advocacy groups and occupational therapists themselves moulded the rehabilitation setting to align their goals more strongly. *The Education Strategy* turns to examine how occupational therapy, namely CAOT, used education to further their professionalization goals. As occupational therapists were uncomfortable in some areas of practice, increasing educational expectations served as an area where CAOT hoped to further occupational therapy's autonomy over its own scope of practice. While CAOT had success in maintaining control over occupational therapy education standards, the university setting for training did not guarantee the attainment of their professional ideal. Finally, *The Gender Challenge* argues that occupational therapists "uniquely female" contributions to the healthcare system both enabled and constrained their professional boundaries as well as their overall participation in the workforce. Through use of a gendered analysis, this chapter highlights a challenge consistently underpinning the professional goals of occupational therapy and clarifies seemingly contradictory decisions as instead the pathway of a female

profession within a patriarchal system. Together, this work weaves the larger historical context into the specific evaluation of Canadian occupational therapy to understand the trajectory of the field's professional identity.

Canadian occupational therapy has a long, rich history of being incredibly self-critical and frustrated as a profession. On a smaller, more individual level however, there is another version of this history, one that involved adapting to changing healthcare settings, advocating strongly for patient and client needs, and making important changes to the practice context. Canadian occupational therapy had significant success when practicing on the level of the individual, while running into numerous challenges scaling up to community or population level concerns. In her unpublished 1967 history of occupational therapy, Helen LeVesconte referred to rehabilitation as "a 20th century mosaic."[93] Throughout the Rehabilitation Era, occupational therapists were frequently caught up in the weeds of practice, having trouble seeing the larger "mosaic" of healthcare systems as well as their place within.

Chapter 1: Legislation and Funding

Over the course of the Rehabilitation Era, the federal and provincial governments made notable legislative changes to healthcare funding and delivery. Through these significant changes came opportunities for occupational therapy to expand and grow the scope of practice, which led to more occupational therapists practicing across Canada. However, occupational therapy,

[93] "History: A Mosaic," 1967, File B2017-0003/012(03), Judith F. Friedland Fonds, University of Toronto, Toronto, Ontario; Judith Friedland and Hadassah Rais, "Helen Primrose LeVesconte: Occupational Therapy Clinician, Education, and Maker of History." *Canadian Journal of Occupational Therapy* 72, no 3 (2005), 131-141; Muriel F. Driver and Isobel M. Robinson, "Tribute Helen P. LeVesconte." *Canadian Journal of Occupational Therapy* 34, no. 3 (1967): 103-105. https://doi.org/10.1177/000841746703400301
Helen Primrose LeVesconte (1896-1982), was an occupational therapist and former director of the occupational therapy program the University of Toronto. Helen was a graduate of the first occupational therapy diploma class, in 1926. She held the role of Director of the occupational therapy program at the University of Toronto for decades, leaving a lasting impression on the role of occupational therapy.

particularly at the national level, had challenges seizing the full range of opportunities available. While occupational therapy was able to develop a profession with a relatively high level of autonomy within the healthcare system, this progress came at the cost of theoretical alignment with the locations of practice. Occupational therapy, with its philosophical roots in community settings, did not find consistent theoretical alignment practicing within hospital settings. Thus, the opportunities available through the legislative changes occurred within a specific framework, namely provincial changes to work within a hospital system using the medical model.

Setting the Stage: Legislative Changes during 1950-1970s

Occupational therapy grew significantly in size and areas of practice during the early years of the Rehabilitation Era, while the profession also attempted to define its scope of practice with more specificity. This decade marked the start of a shifting mentality within the profession, as well as medical science more broadly, in reconceptualizing the goals for rehabilitation patients. Throughout the entire Rehabilitation Era, but particularly in the immediate post-war period, physicians filled a supervisory role in healthcare. In this supervisory position, physicians outlined the overarching goals within areas of healthcare, as well as assigning professionals to support patients reach these goals. Physicians outlined achieving "total possible rehabilitation" as a new and primary goal of occupational therapy in the 1950s and 1960s.[94] Such a mission was in stark contrast to the profession a mere twenty years earlier, when occupational therapists focused on providing individuals with activities to support purpose and meaning in their own lives.[95] The changing language and priorities represent a notable shift in thinking, into a more medicalized,

[94] Quebec Association of Sheltered Workshops Brief to the Health and Welfare Commission, 1961, p 6; E.A. Baker, *The Place of Civilian Rehabilitation in Canada's Social Security Programme*, presented at the National conference on the Rehabilitation 1950. Here, it is relevant to highlight that occupational therapists themselves were not necessarily stating these goals. Rather, it was organizations where occupational therapists were employed, such as Workman's Compensation Boards, taskforces, and supervisors.
[95] Robinson "Muriel Driver Memorial Lecture 1981," 145-152.

remedial approach in healthcare more broadly. This remedial approach did not consistently align with occupational therapy's founding mentality. To understand this shift in focus, it is critical to explore the mindset of the country, both in terms of medical thought and more broadly amongst Canadians.

Canadian citizens were deeply motivated to have better outcomes for veterans returning home from World War II than had been their experience after World War I.[96] Veterans experienced little support returning home from World War I, as the country was not able to adequately support their health and vocational needs. The negative experiences of World War I veterans demonstrated that Canada needed a more comprehensive and longer-term level of support to those returning home. To this end, the federal government instituted a variety of programs and services to support the rehabilitation, re-integration, and future of Canadian veterans after the Second World War.[97] While the criteria for many of these services were narrow and left a large number of individuals excluded, the goals of such programs nonetheless speak to the priorities of Canadians.[98] World War II created a significant number of individuals who had a great variety of healthcare and vocational needs. World War II veterans had a clear identity and were visible in Canadian society due to their service. The visibility, in combination with strong societal support for services, demonstrates the priorities of Canadians in supporting a disabled population. The 'rehabilitation, re-integration, and future' mission represented a priority

[96] Jeff Keshen, "Getting it Right the Second Time Around: The Reintegration of Canadian Veterans of World War II." *The Veterans Charter and Post-World War II Canada* (1998): 62-84; David A. Gerber, "Disabled Veterans, the State, and the Experience of Disability in Western Societies, 1914–1950." *Journal of social history* 36, no. 4 (2003): 899-916; Mark Humphries, "War's Long Shadow: Masculinity, Medicine, and the Gendered Politics of Trauma, 1914–1939." *Canadian Historical Review* 91, no. 3 (2010): 503-531.
[97] Keshen, "Getting it right," 62-84; Mary Tremblay, "Going Back to Main Street: The Development and Impact of Casualty Rehabilitation for Veterans with Disabilities, 1945–1948." *The Veterans Charter and Post World War II Canada* (1997): 160-178; Peter Neary, *On to Civvy Street: Canada's Rehabilitation Program for Veterans of the Second World War*. McGill-Queen's Press-MQUP, 2011.
[98] Keshen, "Getting it right," 62-84; Tremblay, "Going Back to Main Street," 160-178; Neary, *On to Civvy Street.*

supporting injured veterans to return to the closest possible degree of previous functioning. After rehabilitation, the expectation was that veterans could return to the previous occupations or receive training to participate in a new one.[99] This goal of having an occupation was paramount for veterans and society alike. Due to the focus on improved services for veterans, in combination with the vocational goals, Canadian healthcare began significantly expanding their rehabilitation services.

From 1920-1950, there were notable medical advancements that, while not always specific to rehabilitation, increased the general confidence amongst Canadians in medical science.[100] Advances in immunization, nutrition knowledge, and pathology resulted in safer hospitals; each worked to create an expectation of medicine consistently being able to heal. This trend continued with advances in technology and surgical procedures, discovery of synthetic antibiotics, and the mass production of penicillin.[101] The consistent, and fairly rapid, developments in medicine shifted the relationship Canadians had with healthcare, which had cascading impacts into their relationship with and expectations of rehabilitation.

In addition to developments in medicine, World War II is also credited for inspiring a re-evaluation of the concept of disability.[102] Due to advances in medicine and technology enabling more lives to be saved, in combination with the increased number of soldiers fighting, World War II resulted in a high number of disabled individuals wishing to return to Canadian society. In response, the federal and provincial governments created numerous measures to support

[99] Quebec Association of Sheltered Workshops Brief to the Health and Welfare Commission, 1961.
[100] George M. Torrance, "Development of the Canadian Health System." *Health and Canadian Society: Sociological Perspectives* (1998): 3-22.
[101] Allan M. Brandt and Martha Gardner. "The Golden Age of Medicine?" In *Medicine in the Twentieth Century*, 21-37. Taylor & Francis, 2020.
[102] Dustin Galer, "Employers, Disabled Workers, and the War on Attitudes in Late Twentieth-Century Canada." In *Disabling Barriers: Social Movements, Disability History, and the Law*. Edited by Benjamin Isitt and Ravi Malhotra. 1st ed. Vancouver: University of British Columbia Press, 2017. https://doi.org/10.59962/9780774835251: 27- 41.

disabled Canadians. In the 1950s and into the early 1960s, many disability-focused programs were limited to veterans or through worker's compensation boards.[103] As Lyn Jongbloed highlights, discussing disability policy in Canada,

> Adoption of veterans' benefits and workers' compensation programs reflected an assumption that those whose disabilities resulted from serving the economic or military interests of the nation deserved government assistance more than those whose disabilities had arisen in other ways.[104]

Through the mid-1960s, most legislation introduced related to individuals with disabilities focused upon funding remedial rehabilitation services with vocational goals. Many disability advocacy groups looked to extend the support given to veterans around disability hiring campaigns into all disabled individuals in society. Disabled individuals often faced unemployment or subminimum wage and subsequent poverty.[105] The visibility of veterans demonstrated such challenges well, and rehabilitation organizations used this social visibility to build further awareness and support for the broader disabled community. [106] While the welfare state also introduced legislation that supported individuals who were unable to return or participate in the workforce, most of the disability related legislation before the 1970s related to employment.[107] For example, in 1961 the federal government passed the *Vocational Rehabilitation of Disabled Persons Act* (VRDP), which offered "agreements to the provinces and

[103] Lyn Jongbloed, "Disability Policy in Canada: An Overview." *Journal of Disability Policy Studies* 13, no. 4 (2003): 203-209.
[104] Jongbloed. "Disability Policy in Canada," 205.
[105] Megan Rusciano, "Towards Full Inclusion: Addressing the Issue of Income Inequality for People with Disabilities in Canada." In *Disabling Barriers: Social Movements, Disability History, and the Law*. Edited by Benjamin Isitt and Ravi Malhotra, 161-188. Vancouver: University of British Columbia Press, 2017.
[106] Galer, "Employers, Disabled Workers," 27- 41.
[107] Jongbloed, "Disability policy in Canada," 205. "Welfare-state policies introduced in the 1960s included the Vocational Rehabilitation of Disabled Persons Act (1961), which was aimed at returning people with disabilities without other resources to the workplace. It enabled the provinces to recover 50% of vocational training costs related to individuals with disabilities. The Canada Pension Plan (1965) resulted from a federal-provincial agreement to provide a national system of social insurance, which took the form of either a retirement pension, for those in paid employment, or a disability pension." In the 1970s these understandings and approaches change with the politicalization of disability.

the territories for federal sharing of 50 per cent of the costs for a range of services designed to help people with physical or mental disabilities become capable of pursuing a gainful occupation."[108] The VRDP highlights the importance of vocational training in terms of governmental priorities for individuals with disabilities, as the federal government offered to cost-share 50 percent of relevant services, with a wide variety of services included and an open-ended upper limit for cost sharing.[109]

The expectations of the healthcare system and importance of the veteran or worker experience, taken together, clearly demonstrate the priorities of the 1950s for most citizens with a disability: return the individual back to the previous state of functioning.[110] Should a complete return not be possible, the closest possible return should be aimed for instead. Such a way of thinking is clearly in line with the medical model of disability.[111] Throughout the Rehabilitation Era, the medical model of thought is clearly demonstrated through the focus on the impairment of individuals, and aiming to fix these differences. Importantly, this model also gives little consideration to the environment and social conditions as they pertain to disability.[112] In the early years of the Rehabilitation Era, medicine had seen drastic and consistent progress over the previous decades, creating a climate that lent itself to confidence in such a model. Health

[108] Michael J. Prince, "Canadian federalism and disability policy making." *Canadian Journal of Political Science/Revue canadienne de science politique* 34, no. 4 (2001): 795. All provinces participated in this except Quebec (who did in the late 1980s) until VRDP was replaced in the 1990s.
[109] Prince, "Canadian federalism," 791-817.
[110] Turner, Harris. "Pensions for the Blind in Canada—1938." *Journal of Visual Impairment & Blindness* 32, no. 5 (1938): 165-168. https://doi.org/10.1177/0145482X3803200503 This, of course, is focused upon those who have incurred an injury leading to disability that is receptive to rehabilitation and adaption. Those born with disabilities, or who have disabilities considered less receptive to rehabilitative efforts were treated in different ways. For example, income support for the blind was first introduced in 1937 as an early means-tested pension to those over 40, is extended to those over 18 (and the residence requirement reduced from 20 to 10 years) in the early 1950s.
[111] Deborah Marks, "Models of Disability." *Disability and rehabilitation* 19, no. 3 (1997): 85-91.
[112] Marks, "Models of disability," 85-91.

outcomes post injury or illness significantly improved, which led to a general confidence in medicine's ability to "fix."[113]

A 1947 report, titled *The Rehabilitation Needs of the Crippled and Disabled in Canada*, speaks to the mindset of Canadian medicine entering the 1950s. Edward Dunlop, the Head of the Casualty Rehabilitation section of the Department of Veterans Affairs, completed this report, which focuses on the veteran experience and vocational training.[114] Dunlop frequently uses language throughout the report that would suggest he is assessing the needs of all disabled individuals in Canada, as the name suggests. However, throughout this publication it is made clear that he is particularly focused upon disabilities that are most receptive to rehabilitation efforts.[115] Dunlop highlights the new level of knowledge within medical science, stating (referring to individuals with a disability),

> It is only within the compass of this century, that society and science have had the knowledge and skill required to render such people the kinds of services necessary to enable them to become socially and economically useful and independent citizens.[116]

Here, he is arguing that a disability is no longer a limiting experience, so long as individuals can participate in rehabilitation programs. He defined rehabilitation as "the process of assisting the disabled to attain the optimum physical, mental, social, economic and vocational adjustment and usefulness of which they are capable."[117] While this definition includes many facets of life, the discussion is focused on physical capacity and vocational aptitude. His report was one of the largest studies undertaken on the needs of individuals with disabilities, highlighting a new,

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[113] Brandt and Gardner. "The Golden Age of Medicine?" 21-37.
[114] Edward Dunlop, *The Rehabilitation Needs of the Crippled and Disabled in Canada*, 1947; Tremblay, "Going Back to Main Street," 160-178; Dr. Albin T. Jousse, interviewed by Mary Tremblay, 17 January 1991. Oral history archives, Hannah Chair for the History of Medicine, McMaster University, Hamilton, ON. Interview No. HCM T-001-91, 5. Edward Dunlop was a veteran of World War II who lost his sight.
[115] Dunlop, The Rehabilitation Needs of the Crippled and Disabled in Canada, 1947. Dunlop makes clear that he is not talking about children, as that population needs to be explored separately.
[116] Dunlop, The Rehabilitation Needs of the Crippled and Disabled in Canada, 1947, 2.
[117] Dunlop, The Rehabilitation Needs of the Crippled and Disabled in Canada, 1947, 4.

national, interest in supporting disabled citizens. These citizens worthy of support however, going into the 1950s, were motivated, ready, and had the potential to rehabilitate their disability to a degree that they could enter the workforce or duties within the home.[118]

Shortly after the completion of Dunlop's report, in 1951, Canada held a national conference on the Rehabilitation of the Physically Disabled.[119] This conference initiated a National Committee and a National Coordinator of Rehabilitation to provide more structure to the rehabilitation of disabled Canadians.[120] The federal government funded a Provincial Rehabilitation coordinator in every province, whose mission was "to establish a case-finding and case referral system and endeavour to see that, as far as possible, the efforts of the disabled were guided towards productive ends."[121] The use of the phrase "productive ends" feels akin to the meaningful and purposeful goals of earlier occupational therapists working with permanently disabled individuals. However, despite this seemingly similar phrasing, the intended outcome changed significantly. Rather than participating in activities that were productive uses of time due to their meaning, the goal of rehabilitation shifted towards remedial therapy in pursuit of vocational goals. While having a vocational goal was not a change for occupational therapists, "fixing" individuals to return to the workforce was. Therefore, while language did not initially change in rehabilitation settings and seemingly continued to be congruent with occupational therapy philosophies, the intended process became fundamentally different.

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[118] Dunlop, The Rehabilitation Needs of the Crippled and Disabled in Canada, 1947, 3-4.
[119] Dustin Galer, "" Hire the Handicapped!": Disability Rights, Economic Integration and Working Lives in Toronto, Ontario, 1962-2005." PhD diss., 2014.
[120] J.P Lewis, "Commissioned Citizenship: The Evolution of Pedagogical Citizen Construction in Canada, 1947–1994." *American Review of Canadian Studies* 40, no 4 (2010): 478–94. doi:10.1080/02722011.2010.519398. The use of the word "Canadian" is deliberate here, as notions of citizenship is critical in the discussion and treatment of disability.
[121] Ian Campbell, "Co-ordination of Rehabilitation Services in Canada." *International Labour Review* 75 (1957): 34; Galer, "" Hire the Handicapped!"

Friedland, in her 1997 critique of the location of occupational therapy within rehabilitation, highlights the approach to disability in the late 1950s. Quoting Howard Rusk's 1958 *Rehabilitation Medicine: A Textbook on Physical Medicine and Rehabilitation*, Friedland examines how the 1950s introduced the concept of disability as a problem to fix. Rusk, writing 10 years after Dunlop, takes the concept of fixing further, stating that rehabilitation medicine should "eliminate the physical disability if that is possible" as the first step. Subsequent steps included to "reduce or alleviate" the disability if elimination was not possible, and then to "retrain" the individual to a point that they can participate in life and work. This order of importance, and general philosophy towards disability, also firmly positioned physicians as "the leader of the team."[122] As Friedland demonstrates, the nature of eliminating a disability, and therefore identifying the "problem" as the disability itself, was not congruent with previous occupational therapy approaches. For occupational therapists, the problem was "the occupational performance of the person with the disability."[123] Meaning, that a disability itself was not an issue, so long as an individual was able to complete their occupation, however they define it. Such a nuanced understanding of participation and occupation is therefore important in understanding how the Rehabilitation Era ushered in a very different approach to occupational therapy, despite having seemingly similar goals of therapy.

The Canadian government increased funding for those with disabilities, passing the *Medical Rehabilitation Grant* of 1953 and then the *Disabled Persons Act* of 1954.[124] The former established a joint federal provincial program of vocational rehabilitation, while the latter established the basis for a cost-sharing program for supporting disabled adults. These increases

[122] Howard A. Rusk, *Rehabilitation Medicine: A Textbook on Physical Medicine and Rehabilitation*. St. Louis: Mosby, 1958, 7.
[123] Friedland, "An Awkward Alliance," 373
[124] Primeau, "Medical Rehabilitation and Disability Advisory Service," 109-117.

in funding represent a change in rehabilitation opportunities available for Canadians, with a notable number of rehabilitation hospitals being built starting in the 1960s, as well as the potential for the profession of occupational therapy to expand. During the 1950s themselves, despite a shifting landscape in disability awareness and attitudes, most rehabilitation was available through veterans' hospitals, workmen's compensation board centres, and hospitals as part of acute injury treatment. Thus, the "disabilities" that many government funding stipulations referred to were those incurred by an injury and felt possible to change with rehabilitative intervention.

Canadians negotiated the social definition of disability in the context of a changing healthcare landscape. As with the social understanding of disability, World War II had significantly changed the health insurance landscape in Canada.[125] Between 1947 and 1956, Canadians obtained private health insurance, either on their own or through union-negotiated employment programs to pay for medical care. By 1956, roughly one half of Canadians were covered by some form of insurance plan, be it private or public insurance.[126] Although these programs all fell under the umbrella of health insurance, there were significant differences between and within provinces over who paid, which services were covered, and how the program had developed. Before 1957, Canadians were covered by a collection of different insurance policies, to varying degrees, with varying levels of support.[127]

To address the notable inconsistencies in health insurance coverage across Canadians, the federal government passed the *Hospital Insurance and Diagnostic Services Act* in 1957, which offered to reimburse, or cost share, one-half of provincial and territorial costs for specified

[125] Taylor, Malcolm G., and Allan Maslove. *Health insurance and Canadian public policy: The seven decisions that created the health insurance system and their outcomes*. Vol. 213. McGill-Queen's Press-MQUP, 2009; 20-25.
[126] Taylor and Maslove. *Health insurance and Canadian public policy*, 26-93.
[127] Taylor and Maslove. *Health insurance and Canadian public policy*, 26-93.

hospital and diagnostic services.[128] This Act provided for publicly administered universal coverage for a specific set of services under uniform terms and conditions. Four years later in 1961, all Canadian provinces and territories had agreed to provide publicly funded inpatient hospital and diagnostic services. Through the *1966 Medical Care Act* the federal government extended the cost sharing to include physician services, with all provinces and territories opting in by 1972.[129] Provinces were required to establish a system that was universal, comprehensive in coverage, portable between provinces and publicly administered. Faced with rising health care costs, costs, the federal government sought to cap its financial support of health care services in 1977. The *Federal-Provincial Fiscal Arrangements and Established Programs Financing Act* replaced the cost-shared funding with a program of tax points that gave provinces more room to support their systems as well as block financial transfers whose growth rate was capped.[130] Thus, between 1957-1977, the federal government was funding one half of provincial and territorial expenditure on insured hospital and physician services.[131] In 1984, the *Canada Health Act* merged the 1957 hospital care and 1966 physician services legislation, and added a fifth condition on federal funding, that the provincial system be reasonably accessible.[132]

To examine how significant these changes were for Canadians as well as the rehabilitation professions, a case study of Ontario can be used. The Ontario government established the Hospital Services Commission to implement the provisions of the Hospital Insurance and Diagnostic Services Act and organize the hospital system across the province. The commission had five main functions, to:

[128] Taylor and Maslove. *Health insurance and Canadian public policy*, 26-93.
[129] Nancy Miller Chenier, "Health Policy in Canada." *Health Policy* 93 (2002): 4E.
[130] Chenier, "Health Policy in Canada," 4E.
[131] Chenier, "Health Policy in Canada," 4E.
[132] Chenier, "Health Policy in Canada." 4E.

1. Ensure the development throughout Ontario of a balanced and integrated system of hospitals and related health facilities.
2. Approve the establishment of new and additional hospital and related health facilities.
3. Approve the distribution of capital grants for hospital construction and maintenance.
4. Establish and operate alone or in cooperation with others centers for the training of necessary personnel.
5. Institute, organize, and administer a provincial plan of hospital care insurance.[133]

To achieve these goals, the commission created three branches: hospital services, finance, and hospital insurance. The Commission shifted health insurance to be in hospital for all Ontarians, marking a significant transition. After two years of organization and planning, the commission came into effect in January of 1959. By the end of the year, 92.3% of Ontarians were insured under the Commission.[134]

The federal government contributed 44% towards the standard ward cost, which represented a significant shift in health care funding.[135] Previously, most Canadians paid for their healthcare by private insurance companies or out of pocket.[136] While more Canadians had health insurance after the transition to public healthcare, most health services were now overwhelmingly provided through public hospitals. In the case of rehabilitation, there had been limited metrics for assessment due to a "complex network of agencies" delivering rehabilitation services prior to the change in healthcare funding. While this transition represented consolidation and improved tracking for rehabilitation as a whole, for smaller professions such as occupational therapy, these new metrics of success often did not specifically consider them.

[133] "Hospital Services Commission, Annual Reports," Canadian Union of Public Employees. Area Office (Hamilton, Ont.) fonds, Series 8, boxes 25-26, McMaster University.
[134] Hospital Services Commission, Canadian Union of Public Employees.
[135] Hospital Services Commission, Canadian Union of Public Employees.
[136] Hospital Services Commission, Canadian Union of Public Employees.

Over the course of 1961, the Commission evaluated potential services to offer on an out-patient basis, ultimately selecting radiotherapy and physiotherapy.[137] These services subsequently were implemented the following year, in 1962. Occupational therapy is conspicuously missing in this evaluation, which is curious given its evident capacity to be delivered in the community at this time, as well as having a strong ideological fit within the community setting.[138] It becomes clearer as to why physiotherapy over occupational therapy was included when considering the number of therapists employed within the hospital system. Across Canada, in 1961, there were 734 physiotherapists employed in general and allied special hospitals. This represented a rate of 4 physiotherapists per 100 000 Canadians. In sharp contrast, during the same year, there were 150 occupational therapists working in the same settings, representing 0.8 occupational therapists per 100 000 Canadians.[139] Rarely were occupational therapists employed in hospitals with less than 300 beds (this occurred only three times across the nation in 1961), while for physiotherapists the bed minimum typically was 25.[140] These numbers are reflective of the overall percentage of physiotherapists as part of hospital personnel, nearly 0.5%, compared to occupational therapists, nearly 0.1%.[141]

Near the close of the decade, in 1968, both professions saw a significant increase in overall staffing, while the discrepancy between occupational therapy and physiotherapy remained largely the same. Across Canada there were 1658 physiotherapists employed in general

[137] Hospital Services Commission, Canadian Union of Public Employees.
[138] Elizabeth Townsend, *Good Intentions OverRuled: A Critique of Empowerment in the Routine Organization of Mental Health Services.* University of Toronto Press, 1998.
[139] "Health manpower in hospitals, physio-occupational therapists, 1961-68" Dominion Bureau of Statistics, Health and Welfare Division, April 1971. https://publications.gc.ca/collections/collection_2017/statcan/CS83-510-1971-eng.pdf A general hospital is defined as "a hospital which provides for the treatment and care of all types of diseases or at least a wide range of conditions." An allied special hospital is defined as "includes chronic, convalescent, rehabilitation and "other" hospitals."
[140] "Health Manpower," 1971. There was only one physio often employed in these 25-49 bed count hospitals, however, there was consistently one employed.
[141] "Health Manpower," 1971.

and allied special hospitals, representing a rate of 8 physiotherapists per 100 000 Canadians. In the same year, there were 415 occupational therapists working in the same settings, representing 2 occupational therapists per 100 000 Canadians.[142] The total number of paid hours by profession also demonstrate the significant differences between occupational therapy and physiotherapy. There was just over four times as many physiotherapy hours in general and allied special hospitals across Canada compared to occupational therapy hours in 1968.[143] Based on the numbers in practice, it is unsurprising that physiotherapy was selected to be funded in the community, therefore expanding their areas of practice and general visibility. Physiotherapy's philosophical congruence with rehabilitation science in the 1950s and 1960s further supported increased opportunities within the context of an expanding healthcare system.

Evidently, the 1960s saw significant changes in legislation and funding supporting hospitals and healthcare across Canada. While the government assessed the needs of Canadians, both from rehabilitation perspectives and beyond, there was another key negotiation occurring. Physicians were vying to keep their position of power despite the significant change in the overall healthcare system. One central way of maintaining this position of influence and control, in the context of a rapidly expanding healthcare system, was to increase their control over allied healthcare professions.

Since its inception, occupational therapy, in large part due to the scope of practice, has been a role subjugated under physicians.[144] Their subjugated position when entering the change to public healthcare in the 1950s and 1960s proved immensely consequential. During the period leading up to and during the transition to public healthcare, physicians successfully advocated for

[142] "Health Manpower," 1971.
[143] "Health Manpower," 1971.
[144] Robinson "Muriel Driver Memorial Lecture 1981."

control over the expanding number of allied health professionals.[145] While the change in the Canadian healthcare system particularly highlighted physician' pursuit to increase their purview over the ever expanding roles within the umbrella of allied health, such a pursuit was a general trend over the course of the century.[146] Over the course of the 20th century, there was a dance for power between doctors and the state, where doctors desired more control and the state desired increased, yet cheaper, healthcare.

The position of, and approaches by, physicians then are necessary in understanding the creation of occupational therapy scope of practice and professional identity. Friedson argues that,

> 20th century professionalism in medicine became a means of advancing not just the immediate position of doctors in their own field but extending their influence and authority over the ever more complex division of labour in health care.[147]

Therefore, although occupational therapy was already under physician control in the early 20th century, there was increased push to remain firmly under physician control with the transition into public healthcare and the expansion of the healthcare system more generally. According to Gerry Larkin in his chapter in *Regulating the Health Professions*, professionalism meant professional dominance for medicine (physicians), who employed key stratagems to assert their dominance. Two of these stratagems, limitation and increased subordination, impacted allied health professions most significantly.[148] Physicians employed the strategy of limitation through supporting practitioners only when "they operated strictly within areas of practice or body site not claimed by medical or surgical specialities."[149] Through accepting allied health professionals

[145] Gerry Larkin, "The Regulation of the Professions Allied to Medicine." In *Regulating the Health Professions*, 120-133. SAGE Publications Ltd, 2002.
[146] Larkin. "The Regulation of the Professions," 122.
[147] Larkin. "The Regulation of the Professions," 121; Eliot Freidson, *Profession of Medicine: A Study of the Sociology of Applied Knowledge*. University of Chicago Press, 1988.
[148] Larkin. "The Regulation of the Professions," 121. There are four total stratagems proposed by Willis (1983). The first two are 1) integration of rival occupations and 2) obstructing competitive claims from other practitioners to resources controlled by the dominant profession.
[149] Larkin. "The Regulation of the Professions," 121.

who held expertise outside of physicians, while simultaneously enforcing a subordinate status, many allied health professions were bound within specific scopes of practice. This combined approach led to a nuanced understanding of autonomy. Professions such as occupational therapy held expertise outside of a physician's scope, increasing their autonomy when practicing with clients. However, this autonomy was confined within a subordinate status, meaning that occupational therapy needed to be prescribed by physicians to be funded. While physicians were "extending their influence and authority," occupational therapy and similar allied health professions were having to navigate the challenges of this authority and the complexities of asserting professional autonomy.

The expansion of physician influence and authority is related to the evolution in healthcare more generally over the course of the 20th century. Near the beginning of this period, before World War I, medicine was highly siloed. Medical care was also paid for by the individual, and as such the government had relatively little involvement in the healthcare system. Medical care was typically delivered by a single physician, with hospitals focused on specific ailments or treatment approaches.[150] With increases in medical science, population, and the overall healthcare needs of Canadians, the medical system expanded over the course of World War I, the inter-war years, and World War II.[151] This expansion was "dominated by the medical profession but only made possible through a supportive, ever expanding division of labour."[152] Here, the division of labour refers to the increasing number of allied healthcare professions and personnel. With this growth also came the significant increase in government funding at provincial and federal levels.[153] This increase in government funding brought an increase in

[150] Larkin. "The Regulation of the Professions," 122.
[151] Larkin. "The Regulation of the Professions," 122.
[152] Larkin. "The Regulation of the Professions," 122.
[153] Larkin. "The Regulation of the Professions," 122.

government interest, beginning the negotiations between physicians and the state as to who was responsible for medicine.[154] The government was highly interested in cost-effective healthcare, which was at times in conflict with physician-led systems. While physicians successfully campaigned to be in charge of health, the number of patients and their needs far exceeded the capacity for physicians to manage alone. Support-level staffing, with the capacity to implement treatment plans and support specific patient needs, was critical to meet the overall healthcare demand. As such, physicians focused in part on "extending their influence" over the increasing number of allied healthcare professions.[155] Rusk's 1958 textbook highlights the goal of influence well in his discussion of physicians as the "leader of the team" in rehabilitation.[156] Physicians held the most important role of eliminating or reducing physical disability through medical treatment, and subsequently assigning and supervising support-level staff in the re-training component of the patient's trajectory.

Negotiations of Control and Areas of Practice

This extension of physician influence across the healthcare system in the first half of the Rehabilitation Era directly coincides with many allied healthcare professions understanding and deciding their position in the healthcare system. The entrenched positions and approaches to care often hindered the growth of allied healthcare professions. As Larkin states, "… the legacies of previous restrictive practices, demarcations and status distinctions are seen to be obstructing the delivery of effective health care."[157] Such restrictive practices occurred specifically because the formation of many allied healthcare professions occurred directly within a period where physicians were focused on extending their influence. The early years of the Rehabilitation Era

[154] Larkin, Gerald. *Health Professions and the State in Europe*. Taylor & Francis, 1995.
[155] Larkin. "The Regulation of the Professions," 122.
[156] Rusk, *Rehabilitation Medicine.*
[157] Larkin. "The Regulation of the Professions," 122.

was therefore quite diverse in the experience of allied healthcare professions. For those well-established, they were faced with challenges in navigating a new healthcare system with their history of restricted practice. The expansion of opportunities and needs within the healthcare system, however, enabled greater autonomy for certain allied health professionals who held professional expertise over a distinct knowledge base.

While occupational therapy clearly emerged as a technique practised by nurses and some others in the first quarter of the twentieth century, it was slow to develop as a technique practised by a distinct professional group. This latter development began in Canada in the interwar years, as part of the expanding division of labour in healthcare.[158] During the Rehabilitation Era, "knowledge, technologies and treatment options continued to grow" for occupational therapists and other healthcare professions, which continued to facilitate the increased division of labour.[159] Occupational therapy as a profession "developed their own knowledge and skills," particularly through changes made to the educational system.[160] Therefore, as Larkin summarizes, the knowledge base of occupational therapy was,

> … complementary, rather than in some sense secondary to the role of doctors and surgeons. Physiotherapists, occupational therapists and speech therapists had come to work with, rather than for, their medical colleagues in terms of any detailed prescription and supervision by the latter group. Indeed, medical specialization increasingly made doctors familiar with only a part of the spectrum of knowledge and practice required across all medical roles. They could not therefore credibly claim to have any real grasp of the knowledge and skills required by the allied professions.[161]

While physicians maintained the professional supervisory status above many allied health professions, the role of professions such as occupational therapy increasingly could not be simply placed below that of physicians. As healthcare needs, scope of practice, and scientific

[158] Larkin. "The Regulation of the Professions,"124-125.
[159] Larkin. "The Regulation of the Professions," 126.
[160] Larkin. "The Regulation of the Professions," 126.
[161] Larkin. "The Regulation of the Professions," 126.

knowledge all expanded, physicians themselves knew less and less of the role or expertise of occupational therapy.

As Julien Prud'Homme and Antoine Rossignol demonstrate in their chapter on allied health professionals and Medicare in Quebec, the transition to hospital and later medical insurance enabled allied health professions to carve out a novel role in the healthcare system.[162] According to Prud'Homme and Rossignol, allied health professions including occupational therapy, "moved away from nursing by explicitly rejecting the care-based ideal and by pursuing a more medical model of professionalization based upon the ability to evaluate patients and to manage their own patient bases."[163] Their emphasis on the division from nursing is emphasized due to the unique knowledge base other allied health professionalized asserted control over, providing an opportunity to work *with* physicians, as Larkin also highlights.

Occupational therapy was successful in creating a space within the healthcare system where the profession held expertise over a knowledge base that facilitated increased independence. However, unlike similar professions such as physiotherapy and speech and language pathology, occupational therapists ran into challenges clearly articulating the scope of their knowledge base. Compounding their challenges in scope, occupational therapists held an unclear professional identity. With an unclear base, occupational therapy faced significant challenges in creating a space within the healthcare system that felt congruent to their philosophical approaches to practice.

[162] Prud'homme and Rossignol. "From Healthcare Policy to Professional Politics," 266- 285.
[163] Prud'homme and Rossignol. "From Healthcare Policy to Professional Politics," 273; Gregory P. Marchildon and Institute of Public Administration of Canada. *Making Medicare: New Perspectives on the History of Medicare in Canada*. Toronto: Institute of Public Administration of Canada, 2012.

Prud'Homme and Rossignol convincingly use psychologists and physiotherapists as examples of allied health professions who successfully navigated into private markets.[164] Occupational therapy did not enjoy similar success in attempts to move into private markets, for a variety of reasons. One key component of this challenge was determining what professional service occupational therapists were "selling." The field had a mixed relationship with crafts throughout the Rehabilitation Era and was trying to pin down a unifying "thing" they could claim expertise over. Across time, therapists, regions, and settings there was a varied understanding of the nature of occupational therapy.[165] These differences, in turn, led to notable challenges in naming the profession in a digestible way for consumers, which had impacts in both public and private settings. As the Rehabilitation Era progressed, occupational therapy's domain of expertise became increasingly vague. A CAOT sub-committee on the "Role of the Occupational Therapist Now and in the Future," writing in the late 1960s described the role of the occupational therapist by 1980, stating,

> The Occupational Therapist of 1980 will often be a member of a health team composed of medical and para-medical professionals. Since Occupational Therapy is concerned with both physical and mental disability, the Occupational Therapist will be a specialist in one or the other of these areas. The Occupational Therapist's concern with the patient's needs with respect to his occupation will remain primary, but more and more the Occupational Therapist will be concerned with the patient's ability to function in the activities of daily living regardless of the patient's vocation. This broader regard for the general functioning of the patient in society will create numerous roles for the Occupational Therapist that are best defined in terms of the five categories previously mentioned. (pedagogical, managerial, functional assessment, therapeutic, and community).[166]

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[164] Prud'homme and Rossignol. "From Healthcare Policy to Professional Politics," 273.
[165] Jecker and Newell, "Occupational Therapists," 261-278.
[166] "Sub-Committee of the Role of the Occupational Therapist, Now and in the Future" Report to Occupational Therapy Advisory Committee. Evans Papers: Occupational Therapy, 1968-72. McMaster University Health Sciences Archives, Hamilton, ON. 1-3. This vague phrasing continues in each of the elaborations for the five categories listed. For example, the authors define pedagogical skills as "The Occupational Therapist much teach the allied health professions whatever they need to know regarding Occupational Therapy."

The provided definition lists no specific skills or approaches to occupational therapy beyond broad labels such as "physical disability." Despite these vague descriptors, the sub-committee also uses the word "specialist," reflecting this philosophical malalignment. Evidently, CAOT and occupational therapists hoped to be understood as specialists in mental and physical disabilities, supporting individuals in participating in activities of daily living.

In contrast, the Royal Health Commission of 1964 clearly defined occupational therapy, stating,

> Occupational therapy is a rehabilitative procedure guided by a qualified occupational therapist who, under medical supervision, uses self-help, manual, creative, recreational and social, educational, pre-vocational and industrial activities to promote the maximum recovery of the physical and mental functions of patients. Besides treating patients, occupational therapists may also be employed in administrative and teaching positions. In the past, these therapists were primarily engaged in treating long-stay patients in hospitals but in recent years their skills are being used more widely. Today much of their treatment is provided in community workshops, curative workshops, home-care programmes, and to short-stay patients in general hospitals.[167]

Here, the commission used specific descriptors to outline occupational therapy's methods in a therapeutic setting. The contrast in specificity highlights the differences between how occupational therapy groups were defining occupational therapy as compared to external bodies. As occupational therapy increasingly focused on evolving their own definitions, the difference between internal and external perceptions grew.

The challenge of the social perception of occupational therapy is further problematized by the frequent changes in roles and scope of practice for occupational therapists. As Reed and others have shown, the absence of novel knowledge or skill, as well as inconsistent definitions/ areas of practice for occupational therapy have created a fundamental conflict with a definition

[167] *Royal Commission on Health Services: 1964: Volume I*, tabled in the House of Commons on June 19, 1964. https://publications.gc.ca/collections/collection_2016/bcp-pco/Z1-1961-3-1-1-eng.pdf, 60. It reported that two thirds of occupational therapists were employed in mental hospitals, with one third in physical rehabilitation.

of professional and profession. Although occupational therapy often required specific skills and was practiced by a form of registered professional, the profession itself has remained contested.[168]

The high level of difference across settings demonstrates the layered challenges of occupational therapy identity creation. As the educational program taught broadly to standards of practice, with differences in emphasis and areas of focus, in combination with individual therapists' discomfort in medical model hospital settings, there became an increasingly diverse number of areas of practice as the Rehabilitation Era progressed. As areas of practice diversified, it became increasingly challenging to identify specifically the scope of practice for occupational therapists. Unlike other allied health professions, the specific activities that an occupational therapist could complete looked different in different settings. For example, a physiotherapist working in an in-patient, pediatric setting compared to an out-patient, adult setting, would complete broadly the same activities. Despite different populations and locations, physiotherapists examine areas such as range of motion, muscle strength, and pain in both groups.

However, comparing an occupational therapist working in a psychiatric setting to an occupational therapist working in a community pediatric setting, one would have to use increasingly vague descriptors to identify a unifying set of activities. Meaning, similarities between the two occupational therapy roles would include completing meaningful activities and supporting participation in activities of daily living. These terms are not inherently clear to members of the public and look quite different in practice based on the area and population, for example, mental health counselling vs. feeding. Hooper and Wood argue that a component of

[168] Kathlyn L. Reed, "Creating Occupational Therapy: The Challenges to Defining a Profession." *Occupational Therapy in Health Care* 32, no. 2 (2018): 173. https://doi.org/10.1080/07380577.2018.1464238

that evolution resulted in occupational therapy adopting "an interesting mix of pragmatist language regarding the human and structuralist approaches to knowledge, resulting in professional identity problems…"[169] By the end of the Rehabilitation Era, occupational therapists had met most all other practical definitions of a professional. However, the concept of identity comes into play through the social negotiation and recognition pieces of professionalism. With an unclear, or fluctuating identity, professionalism can be easily called into question by the public. Occupational therapists themselves were also highlighting professional scope of practice as a critical issue for the profession. When polled in the early 1970s, "the lack of a clearly defined area of competence" emerged as the number one problem in the occupation as identified by occupational therapists, with 56.5% of respondents ranking this issue as one of their top three problems.[170]

The negotiation of professional scope, especially in the 1960s and 1970s, was evidently an intricate process between physicians, the state, and the profession itself. As the healthcare system expanded, both the state and physicians aimed to have increased control over medicine. Simultaneously, despite their interest in control, physicians alone could not meet the ever-increasing healthcare needs Canadians. The government also wanted a more cost-effective solution leading to the proliferation of allied health. Physicians could not easily fully control all allied health professions as the breadth of each scope of practice quickly became beyond realistic understanding for physicians. Therefore, different allied health professions each achieved varying levels of autonomy over their own scope of practice, influenced by their worth to the healthcare system and the level of control physicians could exercise over the role(s).

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[169] Hooper, Barb, and Wendy Wood. "Pragmatism and Structuralism in Occupational Therapy: The Long Conversation." *The American Journal of Occupational Therapy* 56, no. 1 (2002): 40. https://doi.org/10.5014/ajot.56.1.40

[170] Maxwell & Maxwell, "Occupational Therapy: The Diffident Profession," 59.

Seemingly then, occupational therapy should have increased the control and autonomy over their own scope of practice over the course of the 20th century. While physicians would maintain overall control of the healthcare system and supervisory roles, particularly in hospitals, occupational therapy would have had the opportunity to increase their scope of practice and work increasingly with, rather than for, physicians. In broad strokes, such an expansion did occur.

However, a critical challenge for occupational therapy during this period was their relationship with the biomedical, or more simply the medical, model of medicine. During this time of expansion and increasing physician control over other professions, the medical model was the dominant model in healthcare.[171] From the 1940s through to the 1970s, there were many significant advances in the treatment of formerly fatal or significantly disabling diseases. Thus, in the context of medical advancement centred around curative measures, it is unsurprising that many in medicine took a fixing approach to health. However, there are many illnesses, injuries, and disabilities that cannot be "cured" under this understanding. Other models in medicine and disability account for such conditions, and instead look beyond the level of the person to consider factors that negatively impact a person's health and participation.

Occupational therapy has always been philosophically incongruent with the medical model due to occupational therapist's inclusion of the environment in their therapeutic approach. However, with the change in the healthcare system, allied health professions had to choose whether to align with the medical model. Choosing to highlight a profession's differences with the medical model put professions on a rather deterministic path outside of the typical healthcare system.[172] As physicians were toting the medical model while expanding their control over allied

[171] Marks, Deborah. "Models of Disability." *Disability and Rehabilitation* 19, no. 3 (1997): 85-91.
[172] Susan Nancarrow and Alan Borthwick. *The Allied Health Professions: A Sociological Perspective*. 1st ed. Bristol: Policy Press, 2021. https://doi.org/10.56687/9781447345381. 84- 85. Examples of professions who took this path include chiropractors and osteopaths.

health professions, use of the medical model became important to be included in the healthcare system. As Susan Nancarrow and Alan Borthwick articulate in their monograph titled *The Allied Health Professions*,

> Those that already worked interdependently with medicine, such as in hospitals, were subordinated to medicine and compelled to work under medical direction… professions that were underpinned by heterodox paradigms that did not align with the ascendant biomedical models of mainstream medicine were more easily excluded. Unorthodox practices were considered unscientific and consigned to the margins of legitimate healthcare… their refusal to submit to medical control cut them adrift from mainstream healthcare provision.[173]

Thus, occupational therapy was faced with a decision that necessitated compromise on certain fronts no matter which choice was made. Occupational therapists had to choose between continuing to work under medicine, or to refuse to submit to medicine and attempt to break out from their control and, importantly, from the medical model. Occupational therapists were "compelled" to work under medical direction as the healthcare system evolved due to their history and compounded by gendered forces.[174] Such a choice, however, was deeply uncomfortable as it required using the medical model in practice, which fundamentally did not fit within occupational therapy philosophies. Conversely, to align more strongly with a non-biomedical model would put occupational therapy outside of the "legitimate" healthcare community. Occupational therapy as a profession in the late 1950s and early 1960s, did not have the capacity to choose a path outside of the healthcare system. This choice would have involved a notable shift to many areas of practice, as well as the capacity to work in areas that were not publicly funded.

CAOT, keenly aware of the professional challenges of occupational therapy, commissioned a review of occupational therapist's perspectives on occupational therapy in the

[173] Nancarrow and Borthwick, *The Allied Health Professions*, 84.
[174] Nancarrow and Borthwick, *The Allied Health Professions*, 84.

1970s. Commonly referred to as "The Maxwell Report" due to authors Maxwell and Maxwell, this report presented results of a national survey across Canada of occupational therapists.[175] This report was one of the first national assessments of the profession as a whole and is widely considered a key aspect of Canadian occupational therapy history. The Maxwell Report captures the challenge of physician supervision well, stating,

> While the sponsorship of the medical profession was well-intentioned on the whole, it had both positive and negative effects. Undoubtedly, it led to more rapid development than would have taken place if OT had been a group of women struggling on its own. Male sponsors who were physicians were better able to effect change than female non-physicians. This sponsorship, however, resulted in something less than full autonomy for the group… Although there are obviously problems in the founding and development of a new occupational group, OT seems to have been somewhat long in reaching full maturity.[176]

The report summarizes nicely the unique set of circumstances that hindered occupational therapy during the first two decades of the Rehabilitation Era. Through focusing on the maturity of the profession, the Maxwell Report notes occupational therapy's relatively slow path towards independence and self-governance. Here, the intersection between gender and size of the profession, resulting in physician sponsorship during a particularly impactful period in Canadian healthcare legislation and funding, illuminates the challenges for occupational therapy's political presence.

When taken together with gendered factors, it is unsurprising that occupational therapy as a profession opted to work within the hospital system and attempt to fit their scope of practice into a medical model understanding of health. This significant compromise illuminates a factor in the rationale behind why occupational therapy continued to have challenges with professional recognition and scope of practice. Occupational therapy followed a unique trajectory because of

[175] Maxwell & Maxwell, "Occupational therapy: The diffident profession,"137-139.
[176] Maxwell & Maxwell, "Occupational therapy: The diffident profession," 50.

their difficulties navigating politically, in combination with navigating the inner struggle of fitting themselves into a medical model. Attempting to fit occupational therapy into a model that felt fundamentally incongruent meant that far more time and energy was spent trying to articulate the scope of practice and professional identity. Such a high level of discomfort also influenced occupational therapists frequently seeping into new areas of practice, which further muddled professional identity. Occupational therapy attempting to contort to fit within the medical model led to the profession changing itself in some cases as well as changing the location of practice gradually. Occupational therapy slowly looked outside of hospital systems for employment in part to reduce their use of the medical model. Despite these changes, there are significant challenges left, as highlighted in the above quote, concerning the public healthcare system as it originated in Canada no longer works well for many allied health professions.

Ultimately, at the time of Canadian healthcare transitioning to public healthcare, if occupational therapy wanted to remain in existence, they needed to go into hospitals under physician supervision and use the medical model. However, occupational therapy fundamentally does not work with the medical model. As such, occupational therapists compromised in their scope of practice in various ways, which compound the limited professional identity and lay understanding.

Regulation

Another component of legal professional identity creation was the regulation of occupational therapy. As healthcare is delivered on the provincial and territorial level, each province and territory held the power to regulate occupational therapy as they saw fit. As part of

its professionalization project, CAOT supported regulation efforts across provinces.[177] Legal regulation began shortly after the dissolution of P & OT programs, with Quebec including occupational therapy in the 1972 *Code des professions*.[178] Although CAOT played a role through their board to encourage consistency across provinces, this was a difficult goal to achieve. In the early 1970s, Ontario and Quebec were "powerful legislators," due to their size and history of producing and employing occupational therapists.[179] Further complicating consistency, provincial differences in healthcare delivery and staffing challenges, led many provinces to take a provincially specific approach to occupational therapy regulation.

Beyond these logistical challenges was the precise nature of capturing what constituted occupational therapy's scope of practice. As Townsend shared,

> I remember writing the legislation in PEI, and we were struggling to articulate 'scope of practice' for regulation. In other provinces, the focus on measurable tasks/scope was established. Attention to 'environment' and 'spirituality' (meaningful occupation) did not get embedded in scope. A lost opportunity, but a difficult job when occupational therapy and physiotherapy in other provinces were already setting down a scope that did not really capture the uniqueness of occupational therapy.[180]

Although PEI did not create their regulatory legislation until after the Rehabilitation Era, in 1988, discussions of scope of practice and control over scope date back within the 1960s and 1970s. Through the difficult process of naming occupational therapy expertise, as Townsend highlights, legislation surrounding occupational therapy scope of practice includes discrete,

[177] Justine Jecker and Sarah Newell, "Occupational Therapists," In *Introduction to Health Occupations in Canada,* edited by Ivy Bourgeault. Canadian Health Workforce Partners, Inc, 2023: 269. Occupational therapy remains unregulated today in Canadian territories. In the Northwest Territories and the Yukon, there is relevant legislation that occupational therapy is not currently included in (in the Yukon the *Health Professions Act*, 2003, and in the Northwest Territories the *Health and Social Services Professions Act,* 2015), while in Nunavut there is no relevant statute. In the territories, the title Occupational Therapist is used but not controlled.
[178] Jecker and Newell, "Occupational Therapists," 261-278.
[179] Townsend, Interview; Jecker and Newell, "Occupational Therapists," 261-278. Ontario and Quebec had the highest rate of occupational therapist per 100,000 population (nearly double BC and Alberta, who are close in ranking third and fourth), and graduate the most occupational therapists.
[180] Townsend, personal communication, 2024.

definable tasks, such as assessment of activities of daily living. These tasks were typically on the individual level, and did not capture the full range of a "meaningful occupation." Importantly, legislation influences funding opportunities, and shaped where occupational therapists were employed.

In the context of supervision by another profession, the specific nature of occupational therapy's expertise was important. Occupational therapists struggled to concretely outline a scope of practice that made sense to non-occupational therapists. Further, occupational therapists were attempting to define their scope of practice in a context that pushed them towards remedial rehabilitation and firmly under physician supervision. Legal regulation, however, was an important component of the professionalization project, to ensure that only qualified occupational therapists could hold occupational therapy positions. Ultimately, while the regulation process provided another avenue for occupational therapy to clarify their professional identity, this avenue again was constrained within the larger healthcare system approaches.

Political Prowess and Opportunities Available

Despite the increased employment opportunities for occupational therapy as a whole, the transition to publicly funded healthcare brought increased challenges to navigate political representation. CAOT spent the first 15 years of the rehabilitation period under male physician control.[181] It was not until 1966 that an occupational therapist became the president of CAOT, meaning that a physician navigated the bulk of the transition to publicly funded healthcare. Occupational therapists themselves, through the national work of CAOT, took over in the infancy of public health care, with occupational therapists filling all board positions by 1971.[182]

[181] Physician control ebbed both in practice and on paper over the course of the Rehabilitation Era, as physicians moved more into consultative roles within occupational therapy groups.
[182] Maxwell & Maxwell, "Occupational Therapy: The Diffident Profession,"54-55.

During the mid to later years of the Rehabilitation Era, occupational therapists navigated running CAOT in the context of changes to funding models in each province. Operating at a national level, CAOT frequently ran into challenges navigating provincial and territorial decisions.[183] Some provinces, such as Ontario, Manitoba, Nova Scotia, and Quebec, had strong provincial associations that represented occupational therapy needs within their local setting.[184] However, not all provinces and territories had provincial or territorial representation through their own society. British Columbia, Alberta, New Brunswick, and all of the territories were represented by CAOT throughout the Rehabilitation Era.[185] Both PEI and Newfoundland and Labrador did have their own societies within the Rehabilitation Era, however, had relatively small numbers due to the size of the profession in each province. Given the overall numbers of occupational therapists employed in Canada, as well as the varied representation on smaller scales, CAOT took a leadership role in representation of the profession of occupational therapy.

Through the transition into self-governance, CAOT was actively looking to solidify leadership and improve the organization to strengthen occupational therapy's position as a profession. Rather than honing this foundational block of educating students on professional identity, CAOT chose a multi-pronged approach to look at all facets of professionalism and general understanding due to the broader context of legislative changes in healthcare. During the

[183] Townsend, personal communication, 2024. An example of the challenge of true representation was that not all provincial representatives came from the province they represented.
[184] Judith Friedland. "In the Beginning." *OT Now 3* (2001): 1-4. Ontario was the Ontario Society of Occupational Therapists (OSOT) in 1920, Manitoba was the Canadian Society of Occupational Therapists of Manitoba (CSOTM) formed in 1920, and Quebec was the Quebec Society of Occupational Therapists formed in 1926. Importantly, QSOT was formed by English-speaking occupational therapists in Montreal, and it was not until 1964, with an increase in French-speaking occupational therapists, did the association change their name to Société d'ergothérapie du Québec.
[185] Jecker and Newell, "Occupational Therapists," 261-278. British Columbia does not have a provincial association, instead they have a chapter of CAOT. Alberta got a provincial association in 2003. Saskatchewan has a chapter of CAOT. Nova Scotia has NSSOT, started in 1951. PEI has PEIOTS, started in 1973. New Brunswick NBOT, started in 1988. Newfoundland and Labrador in 1967 got NLAOT. Finally, there is a north chapter of CAOT that supports all territories.

1950s, CAOT began having occupational therapists serve on the board, moving away from physicians alone.[186] CAOT also created a national advisory council and a collection of standing committees. These committees included,

> Editorial, educational, appointments, examination, and clinical training. There were also several special committees responsible for areas such as the convention, standardized equipment, nominations, uniforms, supervisors and the Association's constitution.[187]

Through the bolstering of the association and focus on promoting occupational therapists' voices, CAOT was making a clear effort to improve the perceived legitimacy of the profession. They had some success, with organizations including the Canadian Foundation for Poliomyelitis, the Toronto Branch of the Canadian Cancer Society, and the Canadian Welfare Council each requesting occupational therapy representation.[188] Further, occupational therapists were present at certain government conferences concerning rehabilitation, including the Provincial-Dominion Conference on Rehabilitation in 1951.

Over the course of the 1960s, CAOT took numerous steps to improve the alignment of the composition of Canadian occupational therapists with that of the organization. In addition to having an occupational therapist board and an occupational therapist President, CAOT had actual representation from each province by the early 1970s. Previously, many provinces did not have direct representation, instead having their needs spoken for by Ontarians.[189] According to the Maxwell Report, this transition, directly coinciding with diverse cost-sharing approaches to healthcare between provinces, "forced the association to confront the diversity of views and challenges facing OT across the country and to face more directly the problems of being a

[186] Lynn Cockburn. "The Professional Era," 5-9.
[187] Lynn Cockburn. "The Professional Era," 5-9.
[188] Cockburn, "Change, Expansion," 3-6; Lynn Cockburn. "The Professional Era," 5-9.
[189] This was, naturally, deeply unpopular.

national association."[190] Relevant to its position being a national organization, CAOT's relationships with provincial organizations were logistically of great importance. Many provincial associations had strong membership bases, in part due to their previous lack of CAOT representation. Further, as each province's healthcare system looked different, provincial associations were important in understanding the local context and where advocacy was most needed.

Written in the late 1970s, the Maxwell Report is highly critical of CAOT's relationships with provincial associations. The report states,

> This [the correspondence between national and provincial organizations] is a 'loose' arrangement and the provincial association itself has not formal status in the national organization. Frequently the national office does not know the names of provincial presidents who are elected throughout the year.[191]

The report goes on to recommend improved coordination between provincial and national organizations, as such a relationship is critical in the formation of effective national policy. Given its relatively small size, occupational therapy needed national unity to make compelling arguments for the profession, despite provincial differences. Here, in the context of the early 1970s, CAOT was attempting to navigate an untenable position. As a profession, occupational therapy was small, predominantly composed of women, and undergoing a change in the scope of practice. To be able to navigate the changing landscape, occupational therapy needed national unity to bolster their presence due to their varied size and representation at a provincial/ territorial level. Simultaneously, the Canadian healthcare system had recently undergone a significant overhaul, fundamentally changing and expanding the healthcare system, with differences occurring in each province. This variety across provinces, in combination with

[190] Maxwell & Maxwell, "Occupational therapy: The diffident profession," 55.
[191] Maxwell & Maxwell, "Occupational therapy: The diffident profession," 56.

significant challenges having true provincial representation, led to significant challenge in CAOT's capacity to advocate for occupational therapy consideration in healthcare policy.

The transition to public healthcare was a period of opportunity. However, CAOT was also attempting to find its footing in self-representation by having occupational therapists run the association. The Maxwell Report comments on this challenge CAOT faced looking for individuals to navigate government interactions well. According to the Maxwell Report, occupational therapists had challenges representing themselves in the political arena specifically due to their lack of experience in recent memory. As physicians had run CAOT until the mid 1960s, Maxwell felt that in the late 1970s many occupational therapists remained inexperienced with political discussions. The report states,

> While the relative newness of the profession may be related to a lack of recognition, the long period of dominance by the medical profession may have left a leadership vacuum after 1966. Occupational therapists, lacking a tradition of dealing with government and fighting their own battles, may not have had the knowledge to transmit to the leaders of the profession who have taken over during the last 10 years… Certainly the identification of leadership as a problem, and the recognition of the lack of training of OTs in dealing with government and other professions indicates evidence that there is a leadership problem in the occupation.[192]

Occupational therapy had been guided through the transition to public health care under physician direction, and now as they emerged from this control many were not satisfied with their locations of practice, the image of the profession, or the effectiveness of leadership.[193] Scope, professional identity, effective leadership, and education were among a large group of issues highlighted by occupational therapists themselves.[194] Despite finding themselves in a landscape of increased funding and opportunities, occupational therapists struggled in tackling all the professional issues they were faced with during the Rehabilitation Era.

[192] Maxwell & Maxwell, "Occupational therapy: The diffident profession,"60.
[193] Maxwell & Maxwell, "Occupational therapy: The diffident profession," 60.
[194] Maxwell & Maxwell, "Occupational therapy: The diffident profession," 59 (table 9).

While the majority of occupational therapists were dissatisfied with the leadership in occupational therapy, only a small percentage of occupational therapists were interested in leadership roles. Indeed, when they were polled in the 1970s, only 10 of 835 occupational therapists across Canada ranked the opportunity to fill a leadership role as a top priority in their career. Evidently, while occupational therapists saw the value of leadership, and typically tied leadership to professional identity and understanding, few felt willing to take on the role themselves. For many, professional identity was fundamentally tied to professional leadership, in part due to discomfort many occupational therapists felt in their role as outlined by physicians. As a profession, occupational therapy was therefore keen to define its own role and areas of practice through self-leadership, with goals of creating a coherent and well-understood professional identity. However, these new priorities occurred immediately after the transition into public healthcare, as a reaction to the new roles and reduced clarity of scope. By the mid-1960s, CAOT was faced with professional identity challenges on nearly every front while also starting a new course in self-representation. It is unsurprising that occupational therapy made limited use of the funding available with the transition to public healthcare given its significant internal challenges in professional identity and leadership.

Occupational therapy generally had to manage the position of being an "allied health" professional as well. Canadian occupational therapists are considered allied healthcare professionals, placed in a grouping with a wide array of other professions that complete significantly different roles but remain a comparable distance below the status of a physician. The grouping of various disciplines within a broad, and explicitly lower, status title resulted in limited opportunities for occupational therapists, as well as other allied healthcare fields, to develop professional autonomy. Using Abbott's and Freidson's theories together, the broader

economic and social context did not provide for sufficient system disturbances. While these professions engaged in jurisdiction conflicts amongst themselves, there was not sufficient opportunity to break out from the broad category of allied health until the 1980s. Freidson locates the source of power within professionalism as being "exclusive jurisdiction and control over work."[195] Occupational therapists did not have a high degree of exclusivity, as in healthcare that power was primarily reserved for physicians.

Another layer in the professional recognition of occupational therapists involved the supervision structure within hospitals. In the mid 1960s, hospital staff across Canada tended to be structured as professional departments. Meaning, there would be an occupational therapy department, run by an occupational therapist, who all occupational therapists across programs in the hospital would belong and report to. Having professional departments led to the opportunity for occupational therapists to move up the professional ladder, have a network of colleagues accessible, and have a visible group within the hospital.

CAOT, and therefore occupational therapy, thus spent most of the period with increased funding attempting to develop their own professional identity through internal changes. These changes were inspired by a variety of factors, including changing legislation around healthcare as well as women's participation in the workforce more generally. The Maxwell Report, published in 1977, represented the end of the "drive for maturity" that occurred from 1966-1976, when occupational therapists themselves ran CAOT. During these later years of the Rehabilitation Era, occupational therapy was looking to turn a new page in professional identity, however, the funding opportunities had now significantly changed from earlier in the period.

[195] Freidson. *Professionalism,* 319.

Ultimately, at the time of Canadian healthcare transitioning to public healthcare, if occupational therapy wanted to remain in existence, they needed to go into hospitals under physicians and use the medical model. However, occupational therapy paradigms fundamentally do not work with the medical model. As such, occupational therapists compromised in their scope of practice in various ways, which all compound limited professional identity and the lay understanding. This is not to say that occupational therapy made an error moving into hospitals in this time period of expansion. Rather, modern occupational therapy needs to recognize the entrenched areas of practice due to the historical context and complete a critical evaluation of the appropriateness of occupational therapy areas of practice today.

As the influx of funding for hospitals ebbed in the late 1960s, many chose to restructure their program supervision as a cost-effective measure. However, in the 70s as well as into the 1980s, depending on the area within Canada, hospitals restructured to program-based supervision.[196] In this restructuring, nurses were often program managers. This shift had two notable impacts on occupational therapy: there was reduced visibility within the hospital itself, and there were fewer occupational therapists in management positions. However, there became increased provincial autonomy for healthcare spending, which increased funding available for community-based occupational therapy roles as well.

The restructuring of healthcare systems more broadly represents the second major shift in Canadian healthcare funding within the Rehabilitation Era. The 1977 *Federal-Provincial Fiscal Arrangements and Established Programs Financing Act* and later 1984 *Canada Health Act* marked another change in healthcare funding, and therefore provision within the Rehabilitation

[196] Margo Paterson, Interview by Katie Lewis. September 26, 2023; Inkstater, Interview.

Era. The 1977 Act changed the rules around cost-sharing between the provincial and federal governments, and with this change allowed provinces to use the allotted funds as they saw fit. As Jongbloed and Wendland note in their comparative analysis of Canadian and American occupational therapy funding, the 1977 Act "fostered the development of community and home-based care and occupational therapy positions in these areas increased."[197] Occupational therapy, whose roots lay within community settings, took advantage of these new opportunities and pushed out of hospital settings alone with these new funds available.

Reflecting on her role in founding COTA, Karen Goldenberg discussed the value in bringing occupational therapy back into the community. As Goldenberg describes the rationale for the creation of COTA was threefold, with an outward emphasis on the two reasons benefiting the clients of COTA. Reflecting on a conversation she had with a former classmate discussing the possibility of creating a program to meet community needs, she reflected,

> There's been a request to come up with a proposal for OTs to go into the community. They wanted to create more home-based, community-based services. So, a group of us, five of us wound up as the founders of COTA, Community Occupational Therapy Associates, and it was built on two premises: one that Occupational Therapy was needed in the home to help people adapt to their own environments, not in the basements of hospitals. And to, to help them with their actual lives at home, at work, where they interacted.[198]

These rationale speak to the overall healthcare priorities, at least in Ontario where COTA was founded, in the 1970s. While needing to reduce the burden on the hospital system and improve the efficacy of occupational therapy interventions were the primary and official reasons for beginning COTA, possibilities for employment was also significant and relevant.

[197] Jongbloed, Lyn, and Toby Wendland. "The Impact of Reimbursement Systems on Occupational Therapy Practice in Canada and the United States of America." *Canadian Journal of Occupational Therapy* 69, no. 3 (2002): 145.
[198] Karen Goldenberg, interviewed by Katie Lewis, Toronto, 1 August 2023.

As Goldenberg's recollection and Jongbloed and Wendland's analysis note, occupational therapists were comfortable in community settings and actively looking for these opportunities. However, the legacy of early funding allotments remained prominent in healthcare systems across Canada. While funding did change in the late 1970s, the bulk of healthcare funding remained within hospital settings. Role availability for occupational therapists in community or other private sector settings remained based in provincial and federal funding allocations for disability services. These services have evolved piecemeal over the course of the Rehabilitation Era, within and beyond legislative changes, that gradually supported some occupational therapists to shift out of hospital settings. By the end of the Rehabilitation Era, only 4% of occupational therapists were employed in the private sector, which includes most community settings.[199] By 1998, this percentage jumps to 18%, representing both occupational therapist's interest in working in community settings as well as funding available.[200]

The Shackles of Healthcare Funding

The Rehabilitation Era included multiple, significant shifts in Canadian healthcare funding and legislation. As a collective, occupational therapy had notable challenges in navigating this changing landscape that often did not align well with their philosophies of practice. Early supervision by physicians, funding opportunities available, political prowess, and leadership capacity each influenced occupational therapy's difficulty in successfully advocating for funding in relevant areas to occupational therapy.

With the transition to public hospitals and funding through the 1957 *Hospital Insurance and Diagnostic Services Act* and 1966 *Medical Care Act*, Canadian legislation increased the

[199] Penny Salvatori, "Towards Developing a Flexible Health Workforce/Former des professionnels de la sante faisant preuve de souplesse." *Canadian Journal of Occupational Therapy* 64, no. 2 (1997): 47-53.
[200] Salvatori, "Towards Developing," 47-53.

opportunities available for occupational therapy. These changes in legislation provided opportunity for the expansion of occupational therapy roles and practice, however, this opportunity was not within a national framework. The challenge of federalism played a significant role for occupational therapy, due to their perceived challenges in leadership. As not all provinces had provincial occupational therapy associations, a national association was important to represent and support occupational therapy's needs. However, provinces and territories made the decisions as to where occupational therapy services were funded, meaning that local representation was critical in creating relevant opportunities for occupational therapists.

Ultimately, the public hospital system provided a notable opportunity for occupational therapy as a profession. The restructuring and funding available created a space for occupational therapy to expand significantly. While occupational therapy realized this opportunity and was able to grow the size of the profession, this growth occurred in areas frequently uncomfortable to occupational therapists until the late 1970s. The overarching philosophy of medical care throughout much of the early Rehabilitation Era focused upon the medical model and remedial care. Occupational therapy philosophies poorly aligned with remedial care, further problematizing the profession's ability to realize the extent of the opportunities presented with public Medicare.

Chapter 2: The Challenges for Occupational Therapy in Medical Model Rehabilitation

As the postwar Canadian state proclaimed its responsibility for providing a "high and stable level" of employment, public officials defined productive citizens as those capable of

participating in society through paid employment.[201] Although doctors opposed the introduction of universal public hospital and medical care, their views and the medical model that they championed aligned with this definition of citizenship, and allowed them to shape the structure of the emerging public healthcare system. Because medical doctors increasingly could address ailments that otherwise prevented individuals from fully participating in the paid workforce, public officials valued other health professionals who could do so as well. The rehabilitation model worked well for some other professions such as physiotherapy, because they too could promise to "fix" unproductive citizens. It worked less well for occupational therapists, who resisted the idea of "fixing" individual bodies and took into account the broader environment in which citizens were expected to be productive.

Throughout the Rehabilitation Era, the goal of rehabilitation was to recreate an economically productive individual. In contrast, occupational therapists had developed a practice that rested on productivity as a means rather than an end. While economic participation factored into occupational therapy goals, practitioners contended that the participation in and of itself held therapeutic value on physical and psychological levels. Over the course of the Rehabilitation Era, under physician direction, occupational therapy roles often were constricted to having participation as the end goal, putting limited emphasis on the value of participation beyond physical improvements and increased ability to participate in the economy.

Participation in the economy was in line with findings of the needs of the healthcare system. The federal government funded numerous reports on the state of various groups in Canada needing healthcare, such as *The Rehabilitation Needs of the Crippled and Disabled in*

[201] *Canadian White Paper on Employment and Income* (June 1945), digitized in Federal Reserve Bank of St Louis, FRASER, https://fraser.stlouisfed.org/files/docs/publications/FRB/pages/1945-1949/29840_1945-1949.pdf accessed 21 August 2025.

Canada (1947), Canadian Sickness Survey (1952), A Study on Demobilization and Rehabilitation of the Canadian Armed Forces in the Second World War, 1939-1945 (1960).[202] Those reports all envisioned the purpose of healthcare interventions as healing individuals to the point of them being able to participate in society. They frequently comment on importance of individuals becoming "socially and economically useful" as well as "independent" after their participation in rehabilitation.[203] During this critical period of expansion in Canadian healthcare, there were clear ties between independence and paid work.[204]

The ties between government investment in supporting individuals with disabilities in developing independence was relatively novel during this period. The *Rehabilitation Needs of the Crippled and Disabled in Canada (1947)* was one of the first formal assessments of the needs of disabled individuals themselves.[205] Further, the demobilization study specifically set out to learn "lessons from the First World War" and address critical issues left unsolved in World War I demobilization. One such issue was that of veteran unemployment, stating,

> In fact, for the whole period between the wars, the country had been plagued by unemployment among veterans who had been unsuccessful in re-establishing themselves. In spite of several steps taken… it was not until the Second World War that the employment problem settled itself.[206]

While the reasons for being "unsuccessful in re-establishing themselves" include a variety of different factors, physical and mental capacity to return to society was among these

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[202] Edward Dunlop, The Rehabilitation Needs of the Crippled and Disabled in Canada, 1947; *), A Study on Demobilization and Rehabilitation of the Canadian Armed Forces in the Second World War, 1939-1945 (1960),* https://publications.gc.ca/collections/collection_2016/mdn-dnd/D63-5-97-1960-eng.pdf ; PEART, A. F. W. "Canada's Sickness Survey: Review of Methods." *Canadian Journal of Public Health / Revue Canadienne de Sante'e Publique* 43, no. 10 (1952): 401–14. http://www.jstor.org/stable/41980365.
[203] *Royal Commission on Health Services: 1964: Volume I*, tabled in the House of Commons on June 19, 1964. https://publications.gc.ca/collections/collection_2016/bcp-pco/Z1-1961-3-1-1-eng.pdf
[204] *Royal Commission on Health Services: 1964: Volume I*, tabled in the House of Commons on June 19, 1964. https://publications.gc.ca/collections/collection_2016/bcp-pco/Z1-1961-3-1-1-eng.pdf
[205] Edward Dunlop, The Rehabilitation Needs of the Crippled and Disabled in Canada, 1947.
[206] Edward Dunlop, The Rehabilitation Needs of the Crippled and Disabled in Canada, 1947.

considerations. Later in the report, when considering the physical rehabilitation support available for veterans, the support required for those with additional needs was also addressed. Dr. Ross Millar was assigned to consider the "retraining of special casualties." These individuals included people with disabilities "such as the blind, lame, deaf, seriously maimed, etc."[207] The report states,

> It was obvious that there would be veterans, who had suffered casualties, which would preclude them from resuming pre-war occupations, and whose fields of future activity would be restricted…Before war's end a Casualty Rehabilitation Section was set up within what was then the Rehabilitation Division but is now known as the Welfare Services Division of the Department of Veterans Affairs… The patient has available not only excellent medical and surgical treatment, including orthopaedic appliances, dentures, hearing aids, etc, but, while in hospital, may be given physiotherapy to restore a lost function and occupational therapy in the form of arts and crafts. Training is possible in the vocational field or at university level. The object is to fit the veteran for a job where his disability will not be too much of a handicap; the department even has refrained from using the word "handicapped." This phase of the rehabilitation programme has been very successful."[208]

Here, there is a clear focus on physical rehabilitation leading to paid employment for veterans. This goal is reflective of Canadian society more broadly as well, with the Royal Health Services Commission commenting, "we must also give higher priorities to rehabilitation services so that individuals become self-supporting, and families are restored to independence."[209]

Taken together, while an early focus on the veteran experience led to increased time and attention given to individuals with disabilities more broadly, the overarching goal for those with a disability was being able to obtain employment and therefore independence. To achieve this economically based goal, rehabilitation services primarily aimed to heal or re-train individuals to be able to participate in a vocation that worked for their disability. Focus lay within the

[207] Edward Dunlop, The Rehabilitation Needs of the Crippled and Disabled in Canada, 1947.
[208] https://publications.gc.ca/collections/collection_2016/mdn-dnd/D63-5-97-1960-eng.pdf p 14
[209] *Royal Commission on Health Services: 1964: Volume I*, tabled in the House of Commons on June 19, 1964. https://publications.gc.ca/collections/collection_2016/bcp-pco/Z1-1961-3-1-1-eng.pdf, 18.

individual themselves, with far less emphasis placed upon changing society. The onus lay within the individual to maintain their own health as much as was possible, with hospitals, rehabilitation programs, and other support opportunities focused upon early rehabilitation. Further, individuals were expected to manage or improve their own capacity, rather than looking outside of themselves for support in the form of accommodations or a similar external form of assistance. Canadians were to be healthy and "able" to participate in the economy, without ongoing accommodations from others.

Challenging the "Occupation" in Occupational Therapy

From an external perspective, the ties between occupational therapy and economic participation have often appeared clear. As Kathlyn Reed stated in the 1983 edition of *Concepts of Occupational Therapy*,

> A common error of people who are unfamiliar with occupational therapy is to assume that the word "occupational: is synonymous with the word "vocation." Thus, these people reason that occupational therapy must be concerned with helping people find jobs.[210]

There is the question of how the title of "occupational therapist" interacts with understandings of the rationale for needing occupational therapy. For the lay person, and even for some within healthcare, the term "occupation" has distinct ties to paid employment. Throughout the profession's history, paid work has played a significant role in rationale for therapy.[211] With such a clear tie to employment, it is easy to see how occupational therapy could fit more easily within remedial rehabilitation. The surface-level relationship to employment, may have had cascading impacts into understandings by consumers and managers of the role for occupational therapy.

[210] Kathlyn L Reed and Sharon Nelson Sanderson. *Concepts of Occupational Therapy*. 2nd ed. Baltimore: Williams & Wilkins, 1983, 1-7.
[211] This trend is observed to a lesser degree in paediatric settings, although "occupation" is often deemed to be school for children.

In contrast, occupational therapists do not define occupation specifically as work, but rather as activities and tasks that hold meaning. This definition evolved over the course of the Rehabilitation Era; however, the consideration of meaning remained a consistent theme. Through the consideration and importance of having meaning in occupations, occupational therapy put the responsibility of the purpose for therapy back on the client themselves. This notable contrast between the lay person and occupational therapists' understanding of the term "occupation" led to a difference between the public's view of the role of occupational therapy and the role itself carried out by occupational therapists.[212] Ultimately, this general lack of clarity led to malleability in expertise and flexibility that occupational therapists used to gradually change their role expectations.

At the start of the 1950s, in this context of an expanding healthcare system to support the healing of productive citizens, occupational therapists were well prepared to expand out of veterans' hospitals. In the years leading up to the shift to public health care, in the late 1920s, 1930s and early 1940s, occupational therapists began to work with individuals, typically identified by nurses, who were dependant on family members and/ or institutional services but had the potential to be completing some form of occupation. This type of assessment and rehabilitation process was a shift away from early work with WWI veterans, as diversional activities were an important component of their work. Occupational therapists, as well as the veterans themselves, saw the additional orthopedic value of these diversional activities which had been initially created to engage veterans mentally and divert their minds from their suffering and stressful experience of wartime. Born in the Moral Treatment era, diversion activities aid an individual's recovery through the theory that "no two absorbing thoughts could occupy the mind

[212] Annie Turner and Judith Knight. "A Debate on the Professional Identity of Occupational Therapists." *British Journal of Occupational Therapy* 78, no. 11 (2015): 664-673.

at the same time."[213] During World War II, Canadian occupational therapists sent to Europe often engaged injured soldiers in diversional activities. In this setting, specifically for Canadian occupational therapists and soldiers, diversional activities were considered more important due to the distance soldiers were from home, which resulted in less time spent with visitors or other distracting activities from the stress of war and their injury.[214] Occupational therapists, drawing upon the rehabilitative value of diversional activities, began to see other groups of disabled individuals who could value from both diversion and a vocational form of rehabilitation. These individuals were not veterans, but rather people who had some form of disability that prevented them from engaging in paid occupations of any kind. Diversional activities were completed either as preventative treatment or in conjunction with other physical and vocational treatments to facilitate ongoing participation and morale.[215] Occupational therapists assessed these types of individuals, and then support them in finding and completing activities within their skill set. Occupational therapists also assessed how they could adapt activities to match the individual's physical capacity.[216] These occupational therapists often saw patients who had previously been participating minimally in their life and were dependant on others financially as well as practically. Through these various types of activities occupational therapy helped individuals develop meaning in their lives.

With their expansion in patient base, occupational therapists pivoted their work outside of veterans' hospitals and diversional activities. This pivot laid a strong foundation for the new rehabilitative goals that came out of the hospital system after WWII. The transition out of

[213] Friedland, Judith. "Diversional activity: Does it deserve its bad name?" (1988): 603.
[214] Friedland, Judith. "Diversional activity: Does it deserve its bad name?" (1988): 603-608; Howland, "Occupational Therapy Across Canada," 18-26.
[215] Howland, "Occupational Therapy Across Canada," 18-26.
[216] Cooper, Interview. For example, for an individual who was bed-ridden, occupational therapists developed adaptive looms that fit over a bed so that clients could produce goods without getting out of bed.

veterans' hospitals alone led occupational therapists to become more involved with individuals who previously had no means of occupying their time, be it from a war injury or otherwise. Occupational therapists began working with individuals with ailments such as significant mental health diagnoses or spinal cord injury to participate in meaningful activities. Through these services, occupational therapists expanded their population base and goals to increase participation and productivity in individuals with an impairment previously hindering them from earning any income.

With the start of the Rehabilitation Era, medicine pushed occupational therapy away from diversional activities. Diversional activities, with the premise that distraction through absorption in a task itself is valuable, did not align with a theory of an injured person being a sum of various broken parts. As such, physicians decided that the "occupation" within occupational therapy would be more focused on prescriptive tasks for healing.[217] In the 1950s, with one of the primary objectives for veterans being return to work, occupational therapists appeared well prepared to support this need. Occupational therapists could examine how to "fix" an ailment or injury, as well as explore adaptive measures as needed.

The change from diversional activities into remedial activities demonstrates the fundamental challenge occupational therapy experienced in conveying its expertise outside their own profession. The transition from diversional activities to remedial activities did not always appear as a drastic shift, as there were some similar or overlapping components of each. The underlying philosophy, however, changed significantly and created conditions for occupational therapy to move further from its roots. Occupational therapists did not believe that a remedial approach to occupation, breaking down the activity into discrete, physically oriented

[217] Friedland, Judith. "Diversional activity: Does it deserve its bad name?" (1988): 603-608.

rehabilitative tasks, was most beneficial for individuals, nor where their expertise lay. Through this forced change of practice, the Rehabilitation Era provided the opportunity for occupational therapists to gain clarity on their own profession, although this clarity largely remained within the profession. The discomfort occupational therapists felt completing remedial tasks was a consistent experience and inspired many to define 'occupation' in occupational therapy with greater specificity. While typical roles and responsibilities became clearer over the course of the Rehabilitation Era, occupational therapists also more strongly embedded their unique view of 'occupation.' Challenges in effectively communicating occupational therapy's understanding of occupational to non-occupational therapists remained a challenge for the duration of the Rehabilitation Era. As one interviewee stated, referring to the limited success in occupational therapy's marketing over the course of the Rehabilitation Era, "[the absence of clear external communication] has left us looking like 'odd ducks' rather than brilliant leaders in health and lifestyle."[218]

The Medical Model and Expanding Healthcare System

Due to the healthcare system's focus on economic contributions and individual responsibility, occupational therapy often worked to support disabled individuals to find or obtain methods to contribute economically.[219] Contributing to the economy enabled individuals to be productive while also being independent. When considering the goals of a provincial, or federal, health program, they often reflect the priorities that the government has for its citizens. Often, health care services are focused on "promoting productive citizenship ideals," with a

[218] Townsend, Elizabeth. Interview by Katie Lewis. June 30, 2023.
[219] Judith Friedland, *Restoring the spirit: the beginnings of occupational therapy in Canada, 1890-1930*. McGill-Queen's Press (2011).

heavy focus upon return to work.[220] When citizens return to work after illness or injury, there is a clear metric of success inherently provided. Another main employer of occupational therapists throughout the entire Rehabilitation Era was workplace insurance boards. The types of rehabilitation occurring within workplace insurance board rehabilitation centres were even more explicitly focused upon returning to work and returning to the individual's previous type of employment. For example, the Workmen's Compensation Board had a rehabilitation facility in Malton, Ontario. In a pamphlet given to patients of the facility, they provided an overview of services and expectations of therapy, stating,

> Occupational therapy makes use of woodworking tools, weaving looms, games and other tried and proven ways of speeding your recovery by having you make things yourself, using your hands, arms and legs at the same time preparing you to return to work.[221]

Naturally, the emphasis is placed upon return to work, with occupational therapy occurring in concert with physiotherapy and remedial gymnastics. Both therapies were focused upon physical capacity, being described as,

> Physiotherapy makes use of exercise, electrical, wax and heat treatments, massage and other methods and treatments… Remedial gymnastics are group and individual exercises which include the use of weights and pulleys to help in building up your muscle power.[222]

Through all three of these descriptions, the emphasis lays with physical abilities of the individual's body. The pamphlet contrasts occupational with physical therapy sessions, with men working in a carpentry clinic under the supervision of an occupational therapist and completing hand exercises with a physical therapist. The contrast between the two professions clearly

[220] Geertje Boschma, Sasha Mullally, Megan J. Davies, and Alison Phinney. "Citizenship Theory and Health Practices: Creative Work in Care and Rehabilitation." *BC Studies: The British Columbian Quarterly* 202 (2019): 9-20.
[221] The Workmen's Compensation Board Rehabilitation Centre. Malton, Ontario. Promotional Pamphlet. McMaster University Health Sciences Archives, Hamilton, ON. 9.
[222] The Workmen's Compensation Board Rehabilitation Centre. Malton, Ontario. Promotional Pamphlet. McMaster University Health Sciences Archives, Hamilton, ON. 9.

highlights the vocational component of occupational therapy. In this setting, the pathway is clear: mend your body, train your body, return to work.

The citizenship ideal was not limited to veterans' hospitals and workplace insurance board rehabilitation centres. Disability organizations and other related groups, that would not necessarily have as clear of a tie to work as workplace insurance boards and veterans' hospitals, also consistently highlighted paid employment as a critical goal in the first two decades of the Rehabilitation Era. Amongst disability organizations, occupational therapy was typically mentioned as an additional comment within the physiotherapy department, with their focus on supporting individuals to be physically capable of obtaining employment, i.e. independence, in their communities. Physical therapy and occupational therapy were frequently tied together in discussions of return-to-work, with physical therapists completing physical training and occupational therapists completing vocational training.

As the 1950s progressed, disability organizations increased their advocacy and expansion efforts. For example, by the mid-1950s, the CPA had comfortably moved outside of representing veterans alone. In their 1958 report, the CPA stated,

> We plan to continue this expansion of the rehabilitation services of the association in order to enable the seriously disabled to take full advantage of those advances in medicine and surgery that have given promise of a longer and more useful life.[223]

The focus on the productive component of citizenship is clear. Language such as "useful" implies that to be considered a full citizen, one must be contributing to the economy or to their community. However, the term "useful" does allow a broader interpretation than a specific discussion of work or employment. While still placing a heavy emphasis on productivity in life, the CPA annual statements demonstrate the start of a gradual pivot into non-employment

[223] Canadian Paraplegic Association. *Annual Report* 1958, 9.

priorities as well. The "longer and more useful life" comment also speaks to the start of the deinstitutionalization movement occurring. While useful does speak to employment, it is also speaking to the notion of simply participating in society, through work and other avenues. The concept of independence for individuals with disabilities, initially facilitated through work, expanded into other facets of life.

The CPA was a prominent disability organization, and their priorities speak, to a certain extent, of some of the major goals of disabled Canadians. Importantly, the CPA primarily served individuals who had become disabled over the course of their life. The significant majority of spinal cord injuries the CPA focused upon were incurred during life rather than during childbirth or the prenatal period. Much of the disability-based advocacy in the 1950s and early 1960s was focused on disabilities that had been acquired sometime in later childhood or adulthood. Advocacy for acquired disabilities was the starting point in disability advocacy for several reasons. Typically, these individuals had previously held employment or were participating in society as an able-bodied person. Injured veterans, who inspired much of the rehabilitation funding of the 1940s and early 1950s, fit this description. Individuals who have an acquired disability often have a different relationship with the disability, especially in the immediate post-injury context, because these individuals have an able-bodied baseline as a goal.[224] Such a goal is clearly demonstrated with veteran planning, for example, as many veterans aimed to return to a similar civilian life as before their injury.

As the advocacy in the early decades of the Rehabilitation Era focused on individuals who experienced a disabling event, it is logical that there was a focus on return to work or

[224] Kathleen R. Bogart, "The Role of Disability Self-Concept in Adaptation to Congenital or Acquired Disability." *Rehabilitation Psychology* 59, no. 1 (2014), 107-115; Kathleen R. Bogart, Nicole M. Rosa, and Michael L. Slepian. "Born That Way or Became That Way: Stigma Toward Congenital Versus Acquired Disability." *Group Processes & Intergroup Relations* 22, no. 4 (2019): 594-612.

previous functioning. Returning to a non-disabled baseline inherently involves "fixing," pairing nicely with the medical model in healthcare. In combination with these goals, and in part fueling these goals, were advances in medical science and technology that enabled more lives to be saved. The increase in medical science resulted in more individuals living with disability, rather than dying from a condition, but also increased social expectations of medicine more generally in its ability to save or fix.

Therefore, at the start of the Rehabilitation Era, the convergence of medical science, citizenship ideals, and the common patient in rehabilitation settings led to the use of the medical model and creation of "fixing" based goals in rehabilitation. In this setting, citizenship ideals of participating in the economy can be seen as a backdrop to government funding and priorities. One that aligned well with the state of medical science. Over the course of the Rehabilitation Era, this understanding gradually transitioned towards a social understanding of citizenship and a lessened emphasis on fixing. Indeed, by 1986, rehabilitation was defined as "the process of learning to live with a disability in the context of one's own environment."[225] Learning to live with a disability contrasts notably with a 1947 definition of rehabilitation, "the process of assisting the disabled to attain the optimum physical, mental, social, economic and vocational adjustment and usefulness of which they are capable."[226] By comparing the definition of rehabilitation entering the Rehabilitation Era to the one upon exit, it is clear that significant social change occurred in the understanding of disability in society and therefore in rehabilitative goals.

[225] Roberta B. Trieschmann, *Spinal Cord Injuries: Psychological, Social, and Vocational Rehabilitation*. 2nd ed. New York: Demos, 1988, 147.
[226] Dunlop, The Rehabilitation Needs of the Crippled and Disabled in Canada, 1947, 4.

The CPA clearly demonstrates how the social understanding of citizenship and participation evolved. The CPA began and was run in Ontario, gradually incorporating in different provinces over the course of the 1950s and 1960s. In the 1970s, the Ontario Spinal Cord Injury incorporated, marking the first change from "paraplegic" into "spinal cord injury" to reflect the broader population base that was able to participate in rehabilitation.[227] Individuals with spinal cord injuries that caused more impairment, such as quadriplegic injuries, had previously not participated in rehabilitation as frequently. In part, this was due to their significantly reduced life expectancy, which improved with medical science.[228] The capacity to participate in a vocational based rehabilitation process also impacted this decision- individuals with paraplegia could much more easily participate in work with basic adaptations than those with more significant injuries. Advances in technology in combination with the expansion of worthy goals in rehabilitation, namely those beyond vocational alone, increased the participation of a wider variety of disabilities. It was not until 2012 that the CPA changed its name to Spinal Cord Injury Canada, demonstrating that while change was occurring in the 1970s and early 1980s, there remained a significant influence of productive citizenship goals in rehabilitation.[229]

The CPA is one of many disability organizations that expanded and evolved over the course of the Rehabilitation Era. Many organizations included or were led by individuals with the disability themselves, such as the Canadian National Institute for the Blind and the Council of Canadians with Disabilities, increasing the autonomy individuals felt they had over their

[227] Marian Patterson Holleman, John Sutherland, and Spinal Cord Injury Canada. *From Darkness into Light: The Founding of the Canadian Paraplegic Association*. Toronto, Canada: Printed privately for the Canadian Paraplegic Association, 1991.
[228] Holleman, Sutherland, and Spinal Cord Injury Canada, *From Darkness into Light*.
[229] Holleman, Sutherland, and Spinal Cord Injury Canada, *From Darkness into Light*. "Canadian Paraplegic Association changes its name to Spinal Cord Injury Canada to better reflect the people we serve. When our organization was first established, few people with quadriplegia lived more than a few years."

rehabilitation.[230] Disability organizations were often incredibly vocal for occupational therapy services, regularly writing to universities in support of initiating an occupational therapy program. In the case of the University of British Columbia, various disability organizations wrote in support of keeping the occupational therapy program running when there had been news of the program potentially ending.[231] Disability organizations were critical in advocacy efforts of the needs of the members, and therefore were typically assessing the delivery and development of occupational therapy. These organizations would also advocate to government in support of increasing funding to access occupational therapy services, among other goals for their members.[232]

The priorities of organizations composed of individuals with a specific disability, who were advocating for needs related to their disability, speak to the overall goals of rehabilitation in diagnoses where "full recovery" was not anticipated. These types of disabilities are most relevant in understanding of citizenship and rehabilitation more generally, as short-term acquired injuries have consistently been treated differently in healthcare and society.[233] Total healing underpinned much of the shorter-term rehabilitative efforts, especially in professions such as physiotherapy. For acquired injuries occurring in childhood or adulthood where full recovery was seen as

[230] A. Neufeldt, "Growth and Evolution of Disability Advocacy in Canada." In *Making Equality: History of Advocacy and Persons with Disabilities in Canada.* Edited by D. Stienstra & A. Wight-Felske, 11-32. Toronto: Captus Press, 2003.
[231] Margaret Hood Fonds, Boxes 1 and 3, University of British Columbia Archives, Vancouver, British Columbia. Canadian Arthritis and Rheumatism Society advocated for more training available for occupational therapy (as well as physiotherapy); "General Correspondence, 1981, 1982, 1985" 50-20-1. Faculty of Medicine fonds, University of British Columbia Archives, Vancouver, British Columbia. Across the late 1970s and 1980s there were many individual occupational therapists, representative from hospitals, and representatives from disability organizations writing to the Dean requesting more occupational therapists to be produced by UBC.
[232] Mary Tremblay Fonds, box AAC.NO. 2010.12.6 123.4. McMaster Health Sciences Archives, Hamilton, ON. In Manitoba, July 1955 the Society for Crippled Children and Adults was officially appointed as the central agency responsible for carrying out the provincial rehabilitation program. The society applied for and received provincial and federal grants to fund a variety of things including outpatient treatment.
[233] Bogart, "The Role of Disability," 107-115; Bogart, Rosa, and Slepian, "Born that Way or Became that Way," 594-612.

possible, such as a broken ankle, full rehabilitation was and remains the goal. Medical science more broadly has continued to strive for such a goal, expanding the range of conditions where full recovery is possible. The aspect most relevant to the Rehabilitation Era was the beginning of understanding that life without "full recovery" was possible, fulfilling, and worth funding rehabilitative efforts to support. While individuals did not return to their baseline or fully heal to the degree of being able to participate easily in able-bodied society, disability organizations and society more generally increasingly saw the value in their lives. Overall, citizenship ideals of having productive and active participation in society ebbed and flowed over the course of the Rehabilitation Era, resulting in different goals and patient types for occupational therapists. However, during the critical period of significant expansion in healthcare with the transition to a public healthcare system, disability organizations and citizenship ideals more generally were highly focused on productive citizens with vocations.

Productive Citizenship and the Medical Model

While the Canadian government held responsibility for promoting specific citizenship ideals, the disability rights movement, which gained significant momentum in the 1970s, also heavily influenced the social understanding of citizenship as it relates to disability. The disability rights movement was a social movement focused on promoting social and legal change concerning the treatment of disabled Canadians. A primary aim of the movement was for others to see individuals with a disability as people; people who could participate in all facets of society with appropriate support and fair opportunities.[234]

[234] Aldred Neufeldt and Henry Enns. *In Pursuit of Equal Participation: Canada and Disability at Home and Abroad*. Concord, Ont: Captus Press, 2003, 31- 55. The disability rights movement largely started with citizen volunteers and self-representation, which occurred years before significant government intervention. These organizations raised funds, advocated for increased services available, and generally supported individuals with the same disability. "National voluntary organizations concerned with disability had established themselves not only as advocates, but also as expert organizations in their own right" by the 1970s. World War II increased these efforts,

The disability rights movement used a multi-pronged approach throughout the Rehabilitation Era and beyond, fighting for increased rights, access, and equality. A primary approach was through the court system, as individuals and organizations fought for representation in the law to protect individuals with disabilities.[235] At the beginning of the Rehabilitation Era there were numerous areas of life in Canada that denied rights or attempted to limit the worth of individuals with disabilities. Many children and adults lived in institutions, with Saskatchewan marking the start of deinstitutionalization in 1955.[236] Further, eugenics policies lasted into the early 1970s, with legal sterilization forced upon individuals with disabilities until these Acts were repealed province by province.[237] In 1977, the Canadian Human Rights Act prevented discrimination based on several factors including disability. This contrasted with the 1960s Human Rights Code, which did not address individuals with disabilities specifically.[238]

The 1980s, coinciding with the end of the Rehabilitation Era, marked more significant improvements for individuals with disabilities across Canada. 1981 was the International Year of Disabled Persons, in part inspiring the publication of a report of disability issues in Canada, the Obstacles Report.[239] Shortly thereafter in 1982, the Canadian Charter of Rights and Freedoms included both mental and physical disabilities as a prohibited reasons for discrimination.[240]

"the determination of disabled war veterans to insist on their rights to be treated as citizens with continuing contributions to make raised public consciousness of the importance of community services." The disability rights movement gained significant strength in the late 1970s and early 1980s, building upon decades of campaigning. 1981 marked the International Year of Disabled Persons, representing a new era in disability rights.

[235] Lisa Vanhala. "Disability Rights Activists in the Supreme Court of Canada: Legal Mobilization Theory and Accommodating Social Movements." *Canadian Journal of Political* Science 42, no. 4 (2009), 985.

[236] Wanetta Jane Laird, "A Modern History of Educating Students with Mild Intellectual Disabilities in Saskatchewan (1900-2002)." PhD diss., University of Saskatchewan, 2003.

[237] Vanhala, "Disability Rights," 981-1002.

[238] Vanhala, "Disability Rights," 981-1002.

[239] Vanhala, "Disability Rights," 981-1002.

[240] Dustin Galer, *Working Towards Equity: Disability Rights Activism and Employment in Late Twentieth-Century Canada*. University of Toronto Press, 2018, 79-104.

Stemming from the Canadian Charter, provinces began to codify their own human rights codes, and in doing so increased access to services and independent living while also removing barriers for individuals with disabilities to participate in society.[241] From 1985 onwards, significant legal gains continued to occur for individuals with disabilities, codifying human rights for individuals with disabilities, employment equity, ongoing strategies for integration, among other strategies for equity and inclusion.

The experience of the disability rights movement for individuals with disabilities varied notably across settings and different types of disability. Certain groups took a particularly litigious approach, while others eschewed the court system and focused instead on social change. This is largely due to the challenge of wanting both increased support and increased acceptance, which was often challenging to navigate requests for both, leading to different organizations focusing more heavily on one area.

Regardless of the experience for individuals of the disability rights movement, the timing in relation to the Rehabilitation Era is critical for understanding the development of occupational therapy. Though many of the codified changes occurred after the culmination of the Rehabilitation Era, the seeds for these changes to be realized before the law were sowed during the Rehabilitation Era. Concepts such as deinstitutionalization, occurring over the course of the Rehabilitation Era, had a tangible impact on practicing occupational therapists. Deinstitutionalization, which began in Saskatchewan in the late 1950s with other provinces following suit over the 1960s and 1970s, entailed a rapid closing of institutions, pushing formerly institutionalized individuals into the community. These institutions predominantly

[241] Vanhala, "Disability Rights," 981-1002.

housed individuals experiencing significant mental health issues or children with disabilities.[242] Archie Cooper reflected on her experience in Manitoba, stating,

> When I started off, we used to tell people what to do, you will weave for 20 minutes, whether you like it or not, because I know what's best for you. So, it was very prescriptive, and it was very top down, and then in '67… the whole business of moving people into a, into the community. There was a big movement, in fact, the movement here in Manitoba was, was extreme.[243]

For Cooper, the shift into the community and out of institutions opened many philosophical doors of the role of occupational therapy and supporting the individuals they worked with. In Manitoba and other provinces, there were significant and lasting negative effects of this abrupt transition due to the lack of support for individuals once they got into the community. While, in many cases, deinstitutionalization processes were rushed without adequate preparation for community supports, the concept of this process reflects the changing mentality of rehabilitation and healthcare more generally.[244] However, this shifting mentality towards inclusion began within the context of a healthcare system that had recently been built for remediation. Such a contrast aids in explaining the failures of some of the early community living initiatives, as there was a strong incongruency with the larger system and new approaches to rehabilitation and healthcare.

As Cooper highlights, she herself felt comfortable with this change and recognized the need to become less prescriptive and work more in partnership with clients. Cooper went on to comment that,

> We started to rethink as therapists what our role was. We saw ourselves as enablers, which is an unfortunate term. But I think that there's been a real evolution in how we have thought about disabled people. That we are not the saviours of disabled people. We

[242] Gregory Marchildon, "A House Divided: Deinstitutionalization, Medicare and the Canadian Mental Health Association in Saskatchewan, 1944-1964." *Histoire sociale/Social history* 44, no. 2 (2011): 305-329.
[243] Cooper, interview.
[244] Patricia Sealy and Paul C. Whitehead, "Forty Years of Deinstitutionalization of Psychiatric Services in Canada: An Empirical Assessment," *The Canadian Journal of Psychiatry* 49, no. 4 (2004): 249-257.

> can work in partnership…what does partnership really mean? Well, it means stopping putting yourself out there as the knower of all of everything right?[245]

Cooper credits the concept of partnership being named more specifically in the 1980s, although it was clear across many occupational therapists' experiences that the 1970s marked a change in their thinking about community and partnership, as well as speaking about patients as clients. This change occurred in piecemeal fashion over the 1970s and 1980s, depending on the occupational therapists' level of autonomy and their practice setting. A consistent theme underpinning this evolution of occupational therapists understanding of rehabilitation for individuals with disability was that of true discomfort with the remedial status quo.[246]

Social changes, therefore, including the disability rights and the deinstitutionalization movements helped occupational therapy become more vocal and clearer about their perspective on therapeutic approaches. Considering the individual participating in occupational therapy as a "client" rather than an "patient" for example, began to name the agency occupational therapists looked to give to individuals participating in occupational therapy. Occupational therapy, in part through using environmental considerations, worked with individuals with agency rather than objectified body parts to heal. The term "enablers" which Cooper refers to is an educational term for prompting participation rather than 'doing for.'[247] This shift occurring towards the end of the Rehabilitation Era highlights the goal of occupational therapists to work in a horizontal rather than hierarchical relationship with clients. Such a mission of working with rather than for and

[245] Cooper, interview.
[246] Judith Friedland, "Diversional Activity: Does It Deserve Its Bad Name?" *American Journal of Occupational Therapy.* September 1988, Vol. 42, (no. 9), 603–608. "In the last decade or so, there has again been discontent within the profession. Concern has grown that we have lost much as we have strayed from our original focus on occupation."
[247] Townsend and Polatajko. *Enabling Occupation II*, 9-10.

supporting meaningful occupations, however, did not fit nicely into the hierarchical approach to medicine.[248]

Professional Identity and Occupational Therapist's Discomfort with the Medical Model

The remedial goals of healthcare at that time, in combination with evolving social understandings of productivity, led to the nature of an occupational therapy role becoming more dependent on the occupational therapist themselves. Occupational therapists had varying levels of discomfort in this remedial setting, had varying levels of education in such remedial pursuits, had different levels of autonomy in outlining how they would complete their role, among many other differences that were highly dependent on the immediate setting. Occupational therapists reported high levels of satisfaction working in community settings, in part due to autonomy of the role and in part due to the ease of hospital- based restrictions.[249]

For occupational therapists, the union with return-to-work activities and "fixing," was not always a comfortable one. Across interviews and settings many occupational therapists recalled how they prioritized wanting to see a client's home, what their day-to-day looked like, and how environmental considerations could be factored into areas such as a hospital discharge.[250] For example, an occupational therapist who had transitioned from working in a hospital to a community setting in the early 1980s stated,

> certainly, in the hospital at that time I was treating the problem, what I mean by that is the physical problem, the person here changing the range of motion, working on sensation. In the community, I was working with their ability to live their lives within their environment.[251]

[248] Townsend, interview. She stated, "It made us look weak despite being a mature way of working with active agents versus 'things' (objectified patients)."
[249] Townsend, interview; Sue Baptiste, Interview by Katie Lewis. September 29, 2023; Karen Goldenberg, Interview by Katie Lewis. August 1, 2023; Karen Rebeiro Gruhl, Interview by Katie Lewis. October 3, 2023.
[250] Townsend, interview; Baptiste, Interview; Goldenberg, Interview; Rebeiro Gruhl, Interview.
[251] Emily Etcheverry, Interview by Katie Lewis. October 16, 2023.

She went on to describe the joy she felt when first reading the PEO Model stated,

> when you're meeting people, you, you have all those elements playing in on what you're trying to help them work with right? It's not just range of motion. It's all these things that come in their circumstances, their environment, all of those things.[252]

The PEO Model was first introduced in 1996, but the above interviewee felt it captured her work as an occupational therapist when she transitioned roles. As she highlights, in the latter years of the Rehabilitation Era, through community work she completed a role that felt more in line with the profession itself.

Many occupational therapists also chose to work in a community setting for at least part of their career.[253] While their choice was also influenced by family considerations, this pull into community settings highlights the foundational aspect of the environment in the philosophy of occupational therapy. Occupational therapists have long felt uncomfortable in hospital settings in part due to the absence of environmental considerations, which informed their own understanding of disability. Occupational therapists often report advocating strongly for an environmental assessment of a patient's home or work setting before discharge from a hospital to improve the overall efficacy of occupational therapy and the lives of patients.[254] As occupational therapists consider the environment, and its degree of disabling influence, many occupational therapists felt uncomfortable working in a remedial, medical model, where disability was only considered on the level of an individual.

When reflecting on their understanding of disability, many occupational therapists discussed their discomfort with the word itself, feeling that it did not adequately capture the abilities of the individuals. Coleen Toal, an occupational therapist who primarily worked with

[252] Etcheverry, Interview.
[253] Townsend, interview; Baptiste, Interview; Goldenberg, Interview; Rebeiro Gruhl, Interview.
[254] Townsend, interview; Baptiste, Interview; Goldenberg, Interview; Rebeiro Gruhl, Interview.

children, reflected on her understanding of disability in the early years of her career. Reflecting on the late 1970s and early 1980s, she stated,

> I did use the word disability for years and years and years, not loving it. I like the differently abled kind of concept instead and always tried to promote that when I was working with families, just the idea of differently abled. To me, and families seem to be able to grasp that. OK, they're not disabled. They're not doing it wrong. They're just doing it in a different way.[255]

The medical model and citizenship ideals suggested, in contrast, that individuals with disabilities were doing it wrong if they had a disability that prevented them from participating independently in society in a productive fashion.

Toal was not alone in her understanding of disability that did not align with predominant models of thinking. Anne Carswell, who graduated from McGill in 1963 reflected on her understanding of disability over the course of her career, stating,

> I've always felt that I could make OT what I wanted it to be, which was to get people back into the community, using their God-living talents, I mean just, people with disabilities it, it almost labels them to be non-functional in terms of how people in the community see them, and, I think at some point people call it, we're calling it different abilities, and that may have been or may be another way [of doing].[256]

Here, Carswell names the flexibility of occupational therapy beyond the constraints of the medical model. Her nuanced understanding of disability was facilitated in part due to the flexibility of occupational therapy itself. Carswell is highlighting that she was able to form her own opinion on disability and bring that into her practice of occupational therapy, rather than the medical model that had been taught in school. Pat McKee, a 1974 graduate from a different institution than Carswell echoed a similar sentiment, stating,

> I think I've always been sensitive to the person part. My mother-in-law had polio when she was 14 years old and throughout her life had various challenges that I really was

[255] Coleen Toal, Interview by Katie Lewis. October 3, 2023.
[256] Anne Carswell, Interview by Katie Lewis. September 12, 2023.

> trying to help her with my OT hat. Like I think that when we become OT's, we develop lenses, or we discover we're ready. We have lenses that see things differently.[257]

With this reflection, McKee brings in her personal experience into her role as an occupational therapist, a common approach for many occupational therapists. In her comment of "seeing things differently" she is referring to the considerations of the environment as well as the possibilities of an individual without changing the individual themselves. Such an approach to analyzing individuals in a rehabilitation or healthcare context is, as she highlights, different from prevailing medical thinking at that time.

Finally, Sue Baptiste, an occupational therapist who was educated and practiced in England before moving to Canada in the early 1970s, reflects on a similar experience to the above Canadian-trained therapists. She commented,

> We can be dichotomies or trichotomies? We are this thing, and the more you strip us apart into pieces, the less effective anything you're going to do with me is going to be. I truly believe that because I've seen clients who've really suffered from being fragmented.[258]

Her discussion of fragmentation refers to the approach within the medical model of focusing on discrete abilities of an individual and training those abilities to improve. Baptise, who worked in a variety of adult settings across Ontario before joining McMaster as an educator, felt that an approach informed by the medical model left individuals too fragmented. While this approach can be impactful, for example doing arm exercises to improve strength in one's arm, it often does not adequately address an individual's challenges. For individuals with any disability, they each have a unique life history and environment that may enable or disable their participation in daily life further.

[257] Pat McKee, Interview by Katie Lewis. July 24, 2023.
[258] Baptiste, Interview.

Interestingly, across all interviews, the word "heal" did not come up once. A small handful of interviewees used the word "fix," often in the context of discomfort.[259] Karen Rebeiro Gruhl, reflecting on her own growth as an occupational therapist over the course of her career, reflected,

> I learned that we needed to pay more attention to people as opposed to being, you know, the experts. The expertise was more in the person and sometimes within the family who knew them well. That it wasn't appropriate, nor was it helpful for me to go in to try to fix somebody, but to work collaboratively. I think from that point on, especially because I mean, I worked with mental health people with who are users of mental health systems for the rest of my career in collaborative partnerships. I never took that on the expert kind of position after that. I think, to rehabilitate someone is to assume that we have that knowledge that they need to kinda move on in their life. And I don't agree with that. But that's the way we were taught for sure.[260]

Here, Rebeiro Gruhl is speaking to the uncomfortable position of occupational therapy with the expectation of having expertise in "fixing" individuals. She graduated near the end of the Rehabilitation Era and is reflecting on a change that occurred in the years following. Through her own reflection and comfort level, she describes pivoting from fixing to working collaboratively with individuals to achieve goals that were meaningful for her clients. Rebeiro Gruhl is speaking to the lenses and approaches occupational therapists often used, that came out of their mindset in the therapeutic context rather than a method specifically taught. She is simultaneously highlighting how different occupational therapy can be across occupational therapists, in her discussion of breaking away from methods she was taught, as well as the discomfort with being the "expert" in the therapeutic relationship.

[259] McKee, Interview. The only time the word "fix" was used in the context of truly planning to fix something was Pat McKee, a former professor of mine who was lamenting on the state of occupational therapy today. "So that's what I think about the profession [of occupational therapy]. The profession is mixed up. Welcome to your profession, Katie, that you will fix."
[260] Rebeiro Gruhl, Interview.

Judy Friedland, who would later chair the Occupational Therapy program at the University of Toronto, echoed Karen Rebeiro Gruhl's sentiment in her assessment of the term "rehabilitation" stating,

> Not everyone expects to be returned to their former functional status, which was, you know, the idea. When you see a street of road construction sign and it says rehabilitation of a bridge- it's making it perfect, getting it right again and that is not what we [occupational therapists] do. You know we learn how to cope and how to manage and how to self-manage and so on… To have the same outcome of being meaningfully engaged and having a decent life and everything, but we're not saying we're going to fix your quads.[261]

Friedland, who is vocal in her opposition to occupational therapy being within the umbrella of rehabilitation, articulates this discomfort due to the philosophical misalignment that she feels occurs with occupational therapy and rehabilitation.[262] As she highlights, she does not feel that occupational therapists aim to "fix" much of anything, but rather support learning and navigating the management of any barriers to meaningful participation. Here, again, an occupational therapist who worked within medical models in a larger context of a productive understanding of citizenship is highlighting how fundamentally uncomfortable the union is between occupational therapy and fixing methods. The union, as she contests, does not work on a fundamental level due to the nature of occupational therapy practice. Rather, occupational therapists were put into remedial contexts throughout the Rehabilitation Era that were ultimately a series of missteps away from the roots of true occupational therapy.[263]

Though not as explicitly critical of expectations of "fixing" within the medical model as Rebeiro Gruhl and Friedland, Elizabeth Vipond, when reflecting on her greatest challenges over the course of her career, stated,

[261] Friedland, Interview.
[262] Friedland, "An Awkward Alliance," 373–80.
[263] Friedland, "An Awkward Alliance," 373–80; Friedland, "Why Crafts?" 204-212; Friedland, "Diversional Activity," 603-608.

> When it comes to greatest challenges that work it was sometimes just explaining what, what we were doing... No, I can't make you better. You have to do the work. And um, I think a lot of people don't realize that they go to the doctor, they get better because it gives them a pill and they feel fine… I mean a lot of people go in and say, fix it![264]

Vipond speaks to the change in expectations when it comes to medicine, that individuals would enter the healthcare system, or occupational therapy specifically, with an expectation of being a passive player in the "fixing" process. Vipond opposed this mentality, articulating how important being an active participant in your own healing process was for meaningful recovery. Her frustration speaks to the philosophy within occupational therapy that the therapist and the client are partners in the therapeutic process. In this philosophy, an occupational therapist fundamentally cannot help an individual without the individual also being an active participant in the process.

Overall, occupational therapists had somewhat varying reports of their use of the medical model when it came to disability. These opinions ranged from disappointment to outright contempt, despite these occupational therapists typically working within systems that used the medical model and having been educated in programs that promoted the medical model. Occupational therapists worked within productive understandings of citizenship, as they could use productive understandings to support individuals achieving meaningful vocational rehabilitation, while also incorporating social considerations of citizenship before it became a more commonly understood approach to citizenship on a social level.[265] This difference in timing is reflected through interviewees feelings that models arising in the 1980s and 1990s finally named their approaches to practice. Many occupational therapists reflected that the creation of occupational therapy models, which named the environment specifically as a consideration for

[264] Elizabeth Vipond, interviewed by Katie Lewis. August 18, 2023.
[265] Townsend, interview; Baptiste, Interview; Goldenberg, Interview; Rebeiro Gruhl, Interview; Vipond, Interview.

practice, captured their mentality in the years preceding its publication. One of the central reasons for occupational therapists' reduced use of the medical model, and therefore exclusively productive understandings of citizenship, was their focus on the environment in patient or client interactions.

In the early stages of the Rehabilitation Era, with citizenship ideals focused on productivity and individual responsibility, in combination with the state of medical science, the medical model made some theoretical sense for healthcare more generally. From a philosophical perspective, the medical model posits that the responsibility for disability or any ailment lies within the individual. Healing or helping through the medical model entails making changes on an individual level, rather than to the environment, society, or other more macro-level considerations. Expectations of how individuals participated in society, especially before the mid 1970s, were heavily focused on individual responsibilities and productivity. Of course, in the late 1950s through the 1960s, health care in Canada was also expanding significantly with the advent of publicly funded hospital and medical care. Therefore, during this period of expansion, the medical model of disability was prominent, in part from the prevailing understanding of the expectations of citizens. Occupational therapists were expanding in numbers and in scope in concert with the expansion of healthcare, and frequently working in positions that expected the use of the medical model. However, the medical model did not align with occupational therapy due to considerations of the environment and horizontal approaches to therapeutic relationships.

There were few models and theories that were specific to occupational therapy before the 1980s in Canada. However, these models were in active development in the 1970s and 1980s, frequently looking to amalgamate and name occupational therapy ways of thinking. There was the Model of Human Occupation (MOHO) developed by Gary Kielhofner in 1980, the

Occupational Performance Measure (OPM) first outlined in 1983, and the later OPM(A) which was developed in Australia in 1986. Although these models were created outside of Canada, they reflected many Canadian ideas, and later inspired the CMOP, later the CMOP-E with the addition of engagement) in the 1990s.[266] While the creation of formal models and theories sparked many changes in occupational therapy, one relevant point in the discussion of citizenship and the medical model is the consideration of the environment. The OPM(A) defined occupational performance roles, as, "patterns of occupational behaviour composed of configurations of self-maintenance, productivity, leisure, and rest occupations."[267] Critically, the OPM(A) further refined occupational performance roles as "determined by individual person-environment-performance relationships."[268] Occupational performance, therefore, specifically included an analysis of how a person could perform their occupations in a given environment. This contextualization of performance highlights the crux of the incompatibility with the medical model. As the medical model centres disability within the individual, and therefore rehabilitative efforts focused within the individual, there is no space to be considering the environment.

While the OPM(A) was formally introduced after the Rehabilitation Era, and outside of Canada, the environmental focus is clear to see in the lived experience of occupational therapists in Canada before 1985. Occupational therapists regularly discussed their need to see a patient's home or work environment, later including school environments when children with disabilities more began participating in school, ignoring instructions to focus on factors that lay within the individual alone, and increased participation in accessibility advocacy. Further, occupational

[266] Elizabeth Townsend, personal communication. The CMOP included 'spirituality' which was confusing for some, as well as real-life recognition of 'meaning' as a central concern for occupational therapy.
[267] Judy L. Ranka and Christine J. Chapparo. "Motor Aspects of Upper Limb Functioning and Occupation Analysis." In *Occupation Analysis in Practice* Edt. Lynette Mackenzie and Gjyn O'Toole, (2011), 272. https://doi.org/10.1002/9781118786604.ch18
[268] Ranka and Chapparo, "Motor Aspects," 272.

therapists were consistently uncomfortable with the exclusively remedial focus of hospital systems, especially in the first half of the Rehabilitation Era.[269]

Ultimately, occupational therapists have always considered the individual's environment, though not always explicitly, which has rendered occupational therapy philosophically incongruent with the medical model. Occupational therapists began to name this difference in research and models in the 1980s, but their lived experience demonstrates discomfort with remedial rehabilitation much earlier in their history. Through placing meaning and collaboration at the centre of their work, occupational therapists gradually made changes to remedial rehabilitation over the course of the Rehabilitation Era. This evolution, while constrained by the medical model that dominated the healthcare system, reflects similarly in the progression of rights for individuals with disabilities over the course of the same period. While productive understandings of citizenship played formative roles in the expansion of the healthcare system, these understandings were gradually changed through the disability rights movement and the evolution in understandings of citizenship. In turn, these changes were reflected back into the healthcare system, by occupational therapists and other professionals.

Over the course of the Rehabilitation Era, definitions of citizenship were a consistent theme underpinning many decisions in healthcare. At the start of this period, it was of paramount importance that patients would be able to contribute in some economic way. This goal is seen within rehab departments, government documents, and disability organizations (composed of those with disabilities themselves). Towards the end of the period there is a stronger focus on inherent worth and working towards goals that give life meaning in some way. These changes occur in tandem with the shifting responsibility of health, with a change occurring from

[269] Townsend, interview; Baptiste, Interview; Goldenberg, Interview; Rebeiro Gruhl, Interview. It is important to note that many interviewees were also comfortable with a combination of remedial and compensatory approaches.

individual responsibility to collective and medical responsibility, back towards individual over the course of the era. This responsibility was not only impacted by social understandings of citizenship, as it was also heavily influenced by the evolution of medical science.

The increases in self-representation for individuals with disabilities drastically increased over the course of this period, with individuals with a disability beginning to represent themselves in advocacy groups. This change led, in part, to changes in how disability was discussed and understood socially. Occupational therapists were well prepared for this change to occur, as there were tensions between their perceived importance of the environment and the medical model of disability in occupational therapy. As an environmental analysis is critical for occupational therapists, with occupational therapists examining the patient's environment for disabling factors, they were always philosophically at odds with the medical model of disability as that model argues that disability lies within the individual alone. While occupational therapists were often employed in what would appear to be a medical model setting, the occupational therapy being practiced was not necessarily heavily based on the medical model.

Chapter 3: The Education Strategy

Education and Professional Identity

Occupational therapists, often led by CAOT, used many approaches to help meet the growing demand for their services, with a primary focus on increasing the number of occupational therapy educational programs.[270] Although there were various educational approaches taken during the Rehabilitation era, CAOT prioritized university programs dedicated

[270] CAOT also advocated for only trained occupational therapists to fill occupational therapy roles, for occupational therapy roles to be maintained (rather than given to another profession such as nursing), and assessing the education of internationally trained occupational therapists.

to the practice, with the aim of creating a unified, autonomous, and socially respected health profession. This decision to emphasize training in a university setting, however, created particular challenges in CAOT efforts to build a coherent and respected professional identity. New university programs were championed at each institution by individual occupational therapists, who shaped the culture and focus of the program based on their particular experience in the field. Universities had their own cultures, structures and priorities, which led to programs being placed in different institutional settings, and being subject to particular curricular and research expectations. Some institutions ignored CAOT objections and created combined physical and occupational programs, which necessitated compromises on courses required to graduate. The diversity in educational experiences therefore reduced clarity of the scope of practice and undermined efforts to create a coherent professional identity.

Development of Educational Programs

Canadian occupational therapists employed a multi-pronged approach to help meet the increased demand for their services over the course of the Rehabilitation Era.[271] Occupational therapists pushed into community settings, providing in-home occupational therapy services either privately or through government-funded projects. Although a significant number of members of the profession came to Canada from abroad, particularly from the United States and United Kingdom, the number of educational programs within Canada also grew to increase the number of qualified occupational therapists produced annually. The profession tried to meet the

[271] Margaret Hood Fonds, Boxes 1 and 3, University of British Columbia Archives, Vancouver, British Columbia. Canadian Arthritis and Rheumatism Society advocated for more training available for occupational therapy (as well as physiotherapy); "General Correspondence, 1981, 1982, 1985" 50-20-1. Faculty of Medicine fonds, University of British Columbia Archives, Vancouver, British Columbia. Across the late 1970s and 1980s there were many individual occupational therapists, representative from hospitals, and representatives from disability organizations writing to the Dean requesting more occupational therapists to be produced by UBC. UBC had the greatest number of requests, in part due to a false rumour the rehabilitation programs would be shut down, prompting an outpouring of community requests for the program to remain and expand. Due to the significant demand, increasing occupational therapists tended to be a reactive approach.

increased demand and appropriately staff hospital or rehabilitation facilities as well as meet the community needs for occupational therapy services.[272]

Prior to 1950, the only occupational therapy education program in Canada was at the University of Toronto, located within the Department of University Extension.[273] In 1950, there were two notable changes; McGill University added occupational therapy to its diploma program in physical therapy, therefore doubling the number of Canadian-trained occupational therapists produced annually.[274] Simultaneously, at the University of Toronto, the Faculty of Medicine took over running occupational and physical therapy programs, combining the two programs into one three-year diploma program in 1951.[275] After these changes, both occupational therapy programs offered in Canada were linked with physiotherapy, with students able to make the choice upon graduation of which profession to practice. In 1954, the Université de Montréal added another Physical and Occupational Therapy combined diploma to Canadian educational options.[276]

Criticism of the combined program was immediate amongst occupational therapists, with dissent arising when the programs at McGill University and the University of Toronto were in the planning phase.[277] Occupational therapist groups were principally concerned that most graduates of these programs would pursue physical rather than occupational therapy.[278] As the

[272] Occupational Therapists did of course work in other settings (i.e. community) but the push for community occupational therapists often came from the occupational therapists themselves (e.g. Karen Goldenberg developments) or were outreach components of hospitals.
[273] Friedland, *Restoring the Spirit.* The Department of University Extension was a precursor to the School of Continuing Studies.
[274] Cockburn. "The Professional Era," 7. There were less than 50 graduates produced annually.
[275] Cockburn, "Change, Expansion," 3-6; Lynn Cockburn. "The Professional Era," 5-9; Friedland, "An Awkward Alliance," 373–80; Friedland, "Why Crafts?" 204-212; Friedland, "Diversional Activity," 603-608.
[276] François Hudon and Université de Montréal École de réadaptation. 2004. *Histoire de l'École de Réadaptation de l'Université de Montréal, 1954-2004: Cinquante Années Au Service de La Société*. Montréal: Université de Montréal, Faculté de médecine, École de Réadaptation, Pavillon Marguerite-d'Youville.
[277] Isobel Robinson, interviewed by Judith Friedland, B2017-003, Box 006, file 17, Judith Friedland Fonds, University of Toronto Archives.
[278] Isobel Robinson, interviewed by Judith Friedland, B2017-003, Box 006, file 17, Judith Friedland Fonds, University of Toronto Archives.

initiation of the program at Université de Montréal highlights, however, it was often not occupational therapists themselves who decided on program creation. While neither physiotherapists nor occupational therapists endorsed combined programs and were vocal in their opposition, ultimately the university itself decided on how a new occupational therapy program would begin as well as the format.[279] While occupational therapy and physiotherapy were allowed input into the actual content of course materials once the program was initiated, neither party was able to influence the larger discussions of program format.

In part response to the common criticism of combined programs and in part due to continued demand for occupational therapists, CAOT created and began running the *Special Course* in 1959.[280] This education program was 18 months in length and was considered a "Special Course" in Occupational Therapy, offering an accelerated and occupational therapy-specific education to individuals already holding a university degree.[281] CAOT conducted the *Special Course* out of Queen's University until 1967, when Queen's took over and began its own occupational therapy program.[282] Before the close of the decade, in 1959, the University of Manitoba also initiated a diploma program in occupational therapy.[283]

The 1960s brought additional occupational therapy educational programs. Occupational therapy educators had learned from the experience of the 1950s, now advocating more strongly to create occupational therapy programs that exclusively graduated occupational therapists,

[279] File B2017-0003/016(7), Judith F. Friedland Fonds, University of Toronto, Toronto, Ontario.
[280] "Occupational Therapy Educational Programmes," 1985, File B2017-0003/016, Judith F. Friedland Fonds, University of Toronto, Toronto, Ontario.
[281] "Letter from Isobel Robinson to Flora Thompson," 6 December 1985, File B2017-0003/016 (01), Judith F. Friedland Fonds, University of Toronto, Toronto, Ontario; File B2017-0003/015 (10), Judith F. Friedland Fonds, University of Toronto, Toronto, Ontario
[282] "Special Course," MG28-I495, 1995/0002 5, CAOT Fonds, National Archives, Ottawa; "Occupational Therapy Educational Programmes," 1985, File B2017-0003/016, Judith F. Friedland Fonds, University of Toronto, Toronto, Ontario.
[283] MG28-I495, 1995/0002 17, CAOT Fonds, National Archives, Ottawa; "Occupational Therapy Educational Programmes," 1985, File B2017-0003/016, Judith F. Friedland Fonds, University of Toronto, Toronto, Ontario.

rather than a combined education. The experience of a combined program demonstrated that fewer occupational therapists graduated than physical therapists, and therefore did not adequately meet the demand.[284] The University of Alberta program began in 1960, with the University of British Columbia (UBC) following shortly thereafter in 1961. Université Laval added their occupational therapy program in 1965, with Queen's University following in 1967, replacing the *Special Course*. Rounding out the Rehabilitation Era, the University of Western Ontario began their occupational therapy program in 1971, and Dalhousie University began the first program on the East coast in 1983.[285] Notably, Mohawk College also offered an occupational therapy program beginning in 1975, although this program was not accredited by CAOT and did not produce individuals who could register with CAOT upon graduation.[286] Of all the courses which began in the 1960s, only the UBC course began as a combined program, demonstrating the increased advocacy work on behalf of occupational and physical therapists to have distinct programs.

With the rapid increase in program availability across Canada for occupational therapy, a growing number of differences between programs began to emerge. Some programs graduated students with a baccalaureate degree, while others remained at the diploma level. There were further differences in areas such as if occupational therapy was offered independently or as a combined program with physical therapy, focus within the program, and location within the

[284] Based on thematic trends from the oral history interviews, 2023. This learning was the more salient point for supervisors in academia, although occupational therapists themselves also felt that there was not enough occupational therapy knowledge taught in a combined program. Thematic analysis was completed informally by the author, drawing out relevant themes and similar experiences across interviews.
[285] MG28-I495, 1995/0002 15, CAOT Fonds, National Archives, Ottawa.
[286] MG28-I495, 1995/0002 17, CAOT Fonds, National Archives, Ottawa; Peter Twohig ""Everyone Knows There is a Battle": Colleges, Universities, and the Education of Occupational Therapists in Ontario, 1970-1985." *Historical Studies in Education* 35, no. 1 (2023): 95-116; "Annual Report of C.A.O.T Committee on Standards and Accreditation of Educational Programs," 1972, File B2017-0003/016 (07), Judith F. Friedland Fonds, University of Toronto, Toronto, Ontario.

university. As the *Special Course* and later the Mohawk College program demonstrated, there was also no official requirements for the location of an occupational therapy educational program.

Due to these increasing differences as well as the desire for occupational therapy to have more control over their own profession, CAOT began an independent accreditation process in 1972. Prior to this decision, CAOT participated in a sub-committee of the CMA Committee on Standards of Approval for Education of Allied Health Professionals.[287] At the start of the Rehabilitation Era, occupational therapy education was accredited through the CMA using, at least in part, a document created by the American Medical Association. The University of Toronto and McGill University were both accredited through this process. From 1954 through until the late 1960s, there were multiple documents put out by the CMA, such as the 1960 *Basis of Approval of School of P.T. & O.T.*[288] CAOT also participated in this accreditation process, providing the CMA with the "Outline of Minimum Standards of Training of Occupational Therapists" in 1949. These documents had a limited impact on occupational therapy education, and CAOT felt dissatisfied with the CMA's accreditation process. After making the decision to take over accreditation themselves in the early 1970s, every occupational therapy program across Canada was required to participate in CAOT's process. Through the decision to stop participating in a CMA process, the CAOT committee also set out to "rewrite the basic standards for educational programmes in occupational therapy."[289] In the early 1970s, CAOT felt that the

[287] "Annual Report of C.A.O.T Committee on Standards and Accreditation of Educational Programs," 1972, File B2017-0003/016 (07), Judith F. Friedland Fonds, University of Toronto, Toronto, Ontario; "Notes from Files on Accreditation, Education C.M.A & C.A.O.T," 15 February 1971, File B2017-0003/016 (07), Judith F. Friedland Fonds, University of Toronto, Toronto, Ontario.
[288] "Basis of Approval of Schools of Physical and/or Occupational Therapy in Canada," 1960, Prepared by the Committee on Rehabilitation of the Canadian Medical Association. File B2017-0003/016 (07), Judith F. Friedland Fonds, University of Toronto, Toronto, Ontario.
[289] "Annual Report of C.A.O.T Committee on Standards and Accreditation of Educational Programs," 1972, File B2017-0003/016 (07), Judith F. Friedland Fonds, University of Toronto, Toronto, Ontario.

old accreditation process was "obsolete" and "therefore was not used as a basis for the new standards."[290] While a CMA representative remained on as part of the accreditation process, the CMA no longer controlled accreditation.[291] CAOT highlighted that the profession of occupational therapy had undergone "radical changes," which the new standards attempted to reflect while also recognizing that many changes in occupational therapy were "in the process of evolving."[292] CAOT also felt that the accreditation standards needed to represent that occupational therapists had begun to "practice in areas outside of the traditional medical structure."[293] This process outlined basic standards that had to be met in an occupational therapy program to ensure graduates were appropriately prepared to practice occupational therapy.[294] Graduates from an accredited school could then register with CAOT as a member after completion of their occupational therapy program.

Registration with CAOT was a common request by employers looking to hire occupational therapists before the 1990s.[295] When CAOT began the school accreditation process, the main impact was the ability to become a member of CAOT as a graduate. Outside of Quebec, there were no legal requirements around the use of the title of occupational therapists before the late 1980s, and even then, legislation came in a piecemeal across the nation.[296] Quebec enacted

[290] Annual Report of CAOT Committee on Standards and Accreditation for Educational Programs, 1972.
[291] The CMA representative remained until a new standard was set after the Rehabilitation Era, which allowed the position to be filled by any non-occupational therapist.
[292] Annual Report of CAOT Committee on Standards and Accreditation for Educational Programs, 1972.
[293] "Canadian Association of Occupational Therapists and Canadian Medical Association, Accreditation of Occupational Therapy Educational Programs, Historical Information," 1984, File B2017-0003/016 (07), Judith F. Friedland Fonds, University of Toronto, Toronto, Ontario.
[294] "Canadian Association of Occupational Therapists and Canadian Medical Association, Accreditation of Occupational Therapy Educational Programs, Historical Information," 1984, File B2017-0003/016 (07), Judith F. Friedland Fonds, University of Toronto, Toronto, Ontario.
[295] Jecker and Newell, "Occupational Therapists," 269. Quebec was the only province to legally regulate during the Rehabilitation Era (regulatory body the Ordre des ergotherapeutes du Quebec). Now, Quebec is the only province where there is no requirement to take the national occupational therapy certification examination (administered by CAOT).
[296] Sarah Newell, "Occupational Therapy" In Introduction to the Health Workforce in Canada. Edited by Ivy Bourgealt. 1-14. Canadian Health Workforce Partners, Inc, 2021. https://www.hhr-

the Code des professions in 1973, with New Brunswick and Prince Edward Island following in 1988.[297] Therefore, while registration was a common expectation for occupational therapy jobs, it was not a legal necessity in most areas. As such, in areas that were particularly challenging to hire occupational therapists, such as in remote areas of Canada, CAOT registration was either not a requirement or waved for applicants as needed.[298] Typically, however, registration with CAOT remained an expectation for hiring and was a desirable organization for occupational therapy graduates.[299]

This accreditation process left room for significant differences across programs, allowing for each to develop its own focus and approach to teaching occupational therapy. The standards outlined requirements of the skills required of an occupational therapist, the level of competence of each skill, and the minimum education needed for each skill. It also identified the minimum number of hours for classroom learning and fieldwork experience. With these standards, CAOT experienced significant challenges capturing the reality of present occupational therapy scope of practice while also looking forward with anticipated changes occurring over the 1970s and 1980s. The Occupational Profile, created by Mary Bridle in the 1970s, underpinned the accreditation process and outlined commonalities across occupational therapy that were broad enough to represent different settings. For example, components of an occupational therapy profile included "communicate," "plan and develop programs," and "utilize therapeutic

rhs.ca/images/Intro_to_the_Health_Workforce_in_Canada_Chapters/14_Occupational_Therapy.pdf. The legislation was the 1973 *Code des professions.*

[297] Jecker and Newell, "Occupational Therapists," 269. Other provinces followed suit in years ranging from 1990 to 2015, with no regulation in any of the territories continuing into today.

[298] Helene Polatajko, interviewed by Katie Lewis, Hamilton, 15 August 2023; Tenley Kelly, interviewed by Katie Lewis, zoom (Simcoe County and Hamilton), 11 August 2023; Muriel Westmorland, interviewed by Katie Lewis, Hamilton, 12 July 2023.

[299] Kelly, Interview. Typically, Mohawk students were very upset they could not register with CAOT, writing letters to the association requesting the ability to do so.

procedures." These categories are broad enough to capture different settings, yet also allowed universities to teach with notable differences.[300]

The University of Western Ontario, for example, began its program with four faculty, led by Margaret F. Trider.[301] One of the other founding faculty, Marilyn Ernest (Conibear), reflected on the creation of Western's program,

> The four initial faculty created the curriculum based around Mrs. Trider's 'vision' of a very, very new and different curriculum. [A curriculum] that would concentrate more on assessment and evaluation of the individual and the community, and less on 'cookbook formulae' for treating 11 disabilities.[302]

Trider and her colleagues designed a curriculum with a goal of preparing "future practitioners to provide a service directed towards the prevention, reduction or elimination of incapacity resulting from physical, psychosocial or environmental stress."[303] The University of Western Ontario, therefore, deliberately looked to differentiate its program from others in Canada, using a more preventative, non-medical model philosophy to underpin the curriculum. Western focused on drawing upon standards in research to promote consistent assessment and evaluation methods, instead of blinding following typical treatment paths based on a diagnosis. Western became socially understood as the "no crafts school" and either drew or deterred prospective students based on this image.[304] As Brenda Harper reflected on her process choosing which school to attend in the late 1970s,

> I did research all the different programs in Ontario. I did talk to people and my impression, whether it was accurate or not, was that Queen's was very crafty. There was a lot of, like basket weaving kind of stigma to that, and that OT was coming from that

[300] Mary J. Bridle, "Profile of an Occupational Therapist Revisited." *Canadian Journal of Occupational Therapy* 48, no. 3 (1981): 107-113. https://doi.org/10.1177/000841748104800305
[301] Thelma Sumsion and Joyce MacKinnon. "Our History: An Account of the Development of the School of Occupational Therapy from 1971-2012" Second edition. 2010. 6-9.https://www.uwo.ca/fhs/ot/files/history.pdf The faculty consisted of Mrs. Parker, Mr. Mack, Miss Ernest and Mrs. Trider.
[302] Sumsion and MacKinnon, "Our History."
[303] Sumsion and MacKinnon, "Our History," 11.
[304] Harper, Interview: Lynn Shaw, interviewed by Katie Lewis, August 11, 2023.

> and to being more like science based and, you know, rehab kind of based so I decided to go to Western... I liked what I had heard about the Western program.[305]

Harper's decision-making speaks to the social understanding of high-school students considering occupational therapy. Students clearly understood that their selection of school would impact the type of learning they would receive. Harper grew up a short distance from Kingston, making Queen's an obvious strong consideration for her university education. However, as an individual not particularly drawn to the crafting aspects of occupational therapy, she chose to move further from home to attend a program not focused on crafts. Western's choices championed by Trider in 1971 held up over a decade later in a formal review of the program by J.M. Kiernat, stating,

> The faculty has made a wise choice in deciding that activity processes would not be taught in the professional program... While this approach differs from many schools of occupational therapy at the current time, other curricula are moving in this direction. There is a general consensus among faculty and clinicians that UWO [Western] students quickly learn any of the myriad activities being used in a clinic while on the job.[306]

Although evidently celebratory and looking to market Western's occupational therapy program, the review clearly highlights which components Western's program felt were unique and valuable about their education. The faculty were specifically aiming to approach the instruction and practice of occupational therapy differently than their counterparts.

Western was not alone in their efforts to offer a distinctive occupational therapy program. Dalhousie University developed a curriculum with occupation as the focal point, McMaster University used problem-based learning methods, McGill was the first school to include rehabilitation programs within a Faculty of Medicine, and Queen's University strove to meet local rehabilitation support goals.[307] As each of these schools also began offering occupational

[305] Harper, Interview. This decision was made in the late 1970s.
[306] Sumsion and MacKinnon, "Our History."
[307] Elizabeth Townsend, participating in Barbara O'Shea's interview. Due to significant progression of dementia, O'Shea's interview was not recorded.

therapy in different years, the differences in approaches also reflect the evolving priorities of occupational therapy. Despite the temporal influence, each of these programs remained similar in their messaging by the end of the Rehabilitation Era, representing a continuing difference in occupational therapy education. A university program employing novel approaches to teaching is, of course, a common practice. As universities strive to attract students, they each develop their own identity of teaching and learning to distinguish themselves from competing universities and programs.

However, the variability of occupational therapy education had a particularly strong impact during this period, as occupational therapy was simultaneously undergoing a changing scope of practice. With the rapidly increasing number of occupational therapists practicing in Canada, so too did their areas of practice expand. The diversity of education, in part, facilitated this change in location and scope of practice. Depending on which Canadian educational program an occupational therapist attended, they would have a notably different approach to occupational therapy. As highlighted earlier, a graduate of Western's occupational therapy program would not necessarily choose to draw upon crafting modalities, whereas a Queen's graduate would be more likely to choose such a therapeutic approach. Queen's and Western were not alone, as each school prioritized different goals within occupational therapy education. In the case of combined programs, especially at the University of Toronto, significant compromises were made as to what components of occupational therapy were considered to be critical to be taught to students. The combined program at the University of Toronto contained approximately half of the occupational therapy specific educational components that were included in other programs.[308] Typically, in the case of P & OT programs, occupational therapy was diluted down

[308] Isobel Robinson, interviewed by Judith Friedland, B2017-003, Box 006, file 17, Judith Friedland Fonds, University of Toronto Archives.

to crafting and mental health, as these two areas had little to no overlap with physical therapy and were therefore taught in an occupational therapy specific context.[309]

In the context of the rapidly expanding healthcare system and number of occupational therapists, newly graduated occupational therapists would regularly start occupational therapy departments. As the originator of a department, the occupational therapist tended to also create the culture and focus of occupational therapy in that area. Thus, while each Canadian occupational therapy program having a unique approach may appear to be congruent with university-level education typically, in the larger context of the field of occupational therapy, it facilitated the increasing diversity of practice and reduced the clarity of scope of practice. The combination of such a varied educational experience between educational programs with many new opportunities for employment mutually reinforced each other to expand the scope of practice for occupational therapists.

With scrutiny of educational focus so came the expectations of professors with the program striving to remain at the university level. Occupational therapy actively strove to remain at the university level, and as such the educational expectations of professors increased. Through the 1950s and 1960s, occupational therapy professors did not have any post graduate training. Helene Polatajko, who worked as an occupational therapy professor at Western as well as the University of Toronto, reflected on her decision-making process to pursue a PhD, commenting,

> I had no idea that a PhD could teach university in OT because I had never seen an OT with a PhD. There was no such thing, so most of the people who taught me were bachelor's and some of them were still the diplomas.[310]

[309] Isobel Robinson, interviewed by Judith Friedland, B2017-003, Box 006, file 17, Judith Friedland Fonds, University of Toronto Archives.
[310] Helene Polatajko, interviewed by Katie Lewis, Hamilton, 15 August 2023.

Polatajko ultimately pursued a PhD in educational psychology and measurement, working within the faculty of education upon completion of her degree.[311] Indeed, by the early 1970s, there remained almost no occupational therapists who also held a PhD. Polatajko was selected to complete a formal evaluation of a new occupational therapy program due to the few options available.[312] However, CAOT was also insisting that occupational therapy had to be taught at the university level, earning a baccalaureate degree.[313] CAOT set a bachelor's degree as a minimum requirement in 1971, and restricted membership to those who graduated from an approved university program. At the same time, to be within a university, educational requirements of professors continued to increase. To keep up with these outlined expectations from within universities as well as CAOT, occupational therapy programs began firmly insisting that their professors have master's and later doctoral degrees.[314] One notable challenge with such an expectation was the absence of master's or doctoral-level occupational therapy programs in universities.

Occupational therapists pursued PhDs in areas including psychology, epidemiology, anatomy, and education, among others, and returned to, or often continued to, teach in the occupational therapy program.[315] While many occupational therapists aimed at relating their PhD to occupational therapy challenges or issues within practice, there were varying degrees of

[311] Polatajko, Interview. There was limited measurement in occupational therapy (she argues this continues to be an issue) and she brought standardization into occupational therapy.
[312] Polatajko, interview. She recalled, "it's time to evaluate the Mohawk Program so the OTs on the committee… insist that it has to be an OT who does the evaluation. The Non-OTs on the committee, insist it has to be a PhD… Marilyn Earnest was working with me at Western, she knew I had a PhD. So Marilyn Earnest says Helene Polatajko should do it because she's the only PhD we got. So that's how I ended up doing that study." As Polatajko recalls, in the early 1970s CAOT could find only one occupational therapist who held a PhD.
[313] "Annual Report of C.A.O.T Committee on Standards and Accreditation of Educational Programs," 1972, File B2017-0003/016 (07), Judith F. Friedland Fonds, University of Toronto, Toronto, Ontario.
[314] Anne Carswell, interviewed by Katie Lewis, Vineland, 12 September 2023; Judith Friedland, interviewed by Katie Lewis, Zoom (Toronto and Hamilton), 1 August 2023.
[315] Cooper, interview; Polatajko, interview.

success as the core of their PhD experience lay in another department. Polatajko, again reflecting on her pursuit of a PhD,

> Part of it has to do with who will take you? Right, because you didn't have the proper undergraduate degree. I tried to do my PhD in Neuro Psych at Western with the top neuroscientist at the time. But I didn't have an undergrad degree in psychology, and they wouldn't take you to do a psychology degree without an undergrad degree in psychology.[316]

While finding a department and supervisor who felt comfortable looking past a different undergraduate or master's level degree was the first challenge, the second came in the form of tying the PhD based in another department to occupational therapy. Polatajko comments,

> The PhDs are becoming PhDs in other areas, so they're not going to do an OT type PhD because if you're doing a PhD in anatomy, you're going to do an anatomy PhD question... If you're doing a PhD in history, then it's going to be a history kind of question, but your PhD is always driven by the discipline, the kind of question you're allowed to ask is driven by the discipline."[317]

Occupational therapy educators were increasingly gaining advanced education in an occupational therapy adjacent area. While their undergraduate degrees or diplomas were in occupational therapy, and many practiced occupational therapy for a time during their clinical career, their specific research expertise was based in other fields. Polatajko worked within the faculty of education, where she had obtained her PhD. Archie Cooper worked within the department of anatomy where she obtained her master's and PhD before moving to teach occupational therapy at the University of Manitoba. Mary Ann McColl, who taught at Queen's University, obtained both her master's and PhD in epidemiology and biostatistics, and subsequently worked in epidemiology for years before returning to teach in occupational therapy departments.[318] Pat McKee got her PhD in anatomy, working in the anatomy department at the University of Alberta

[316] Polatajko, interview.
[317] Polatajko, interview.
[318] Mary Ann McColl, Interview by Katie Lewis. July 18, 2023; Cooper, interview; Polatajko, interview.

before moving to Ontario and occupational therapy department at the University of Toronto. She reflected that while working at the University of Alberta, "when I was in the anatomy department, I was not seen as an OT. No, I was just seen as an academic and an anatomist."[319] These women are four of many examples of occupational therapy professors that have experience through their education and work outside of occupational therapy. Regardless of their pathway into occupational therapy education, occupational therapy educators ultimately obtained expertise in an area of varying relation to occupational therapy, and it was up to the individuals themselves to tie their research to occupational therapy and later occupational science.

Importantly, occupational therapy education, at the undergraduate level, produced generalist graduates.[320] The expectation of graduating generalist practitioners helped facilitate the different approaches each university took to occupational therapy education as each program could put more emphasis on different areas, or take varied approaches to instruction within the broad goal of producing generalists. Programs producing generalists therefore had a broad foundational knowledge of occupational therapy, with any advanced understanding in certain areas being guided by the professors' areas of expertise. As these areas of expertise were guided by other programs and tied back to occupational therapy by individuals themselves, this further catalyzed the diversity and individuality of practice.

Each program's unique approach to occupational therapy, taught by a variety of professors with different backgrounds, was compounded by their different locations within each university. Across Canada, occupational therapy programs found themselves nested within larger programs to varying degrees and with varying autonomy over decision making processes. The

[319] McKee, Interview.
[320] The goal of producing generalists, despite comments on planning to become specialists, remains the case today, even with a master's level entry to practice standard.

University of Manitoba's occupational therapy program began as a department within a School of Rehabilitation Sciences, which was located within the Faculty of Medicine. [321] Since its inception, it has evolved into a department within a College of Rehabilitation Science that is within the Rady Faculty of Health Sciences. The program at the University of Alberta began and has remained as a department of occupational therapy within a Faculty of Rehabilitation Medicine.[322] The University of Toronto program moved from the Department of Extension into a part of the Division of Rehabilitation Medicine within the Faculty of Medicine in 1950.[323] When occupational therapy separated from physical therapy and became its own program again in 1971, occupational therapy became a department, remaining within the Faculty of Medicine.[324] The University of Western Ontario began as a department of occupational therapy within the Faculty of Medicine, physically located in the basement of the dental sciences building. In 1984, the department moved from the Faculty of Medicine to the newly created Faculty of Applied Health Sciences.[325] At Queen's University, CAOT had been running their *Special Course* in Kingston, often paying to use Queen's locations and faculty. The School of Rehabilitation Therapy, which housed a department of occupational therapy, began in 1967 within the Faculty of Medicine.[326] The school was housed in temporary facilities for the first 5 years of the program, ultimately moving to its own building in 1972.[327] In 1988, a new Faculty of Health Sciences was formed incorporating the Schools of Nursing, Rehabilitation Therapy and Medicine.[328] At McGill University, the School of Physiotherapy was established in 1943 and

[321] Cooper, interview. Archie describes it as a "captive school."
[322] File B2017-0003/016 (07), Judith F. Friedland Fonds, University of Toronto, Toronto, Ontario.
[323] File B2017-0003/016 (07), Judith F. Friedland Fonds, University of Toronto, Toronto, Ontario.
[324] File B2017-0003/016 (07), Judith F. Friedland Fonds, University of Toronto, Toronto, Ontario.
[325] Sumsion and MacKinnon, "Our History." found a home there, not pushed out they welcomed the change
[326] File B2017-0003/016 (07), Judith F. Friedland Fonds, University of Toronto, Toronto, Ontario.
[327] Jecker and Newell, "Occupational Therapists," 267-270.
[328] Jecker and Newell, "Occupational Therapists," 267-270

was the first in Canada to be part of a faculty of medicine. In 1950, occupational therapy was introduced in a three-year diploma program combining physical and occupational therapy.[329] At the University of British Columbia, occupational therapy began as a member of the School of Rehabilitation Medicine in 1961, renamed the School or Rehabilitation Sciences in 1992, evolving into its own department in 2007.[330] The Université de Montreal formed a School of Physical and Occupational Therapy, within their Faculty of Medicine, later becoming School of Rehabilitation when the university added Speech and Language Pathology to their rehabilitation program offerings. In 1962, when occupational therapy and physical therapy separated, each program became a department within the School of Rehabilitation.[331] Finally, at Université Laval, their independent occupational therapy program began in 1968, as a department within the Faculty of Medicine.[332] As the Rehabilitation Era was evolving beyond the early 1980s, there was a notable gap in Canada's occupational therapy education, without a program east of Montreal. Students interested in occupational therapy in the Atlantic Region (Newfoundland and Labrador, New Brunswick, Nova Scotia and Prince Edward Island) had to compete for places outside the region. Only a few returned after graduation meaning that occupational therapy was slow to grow in Atlantic Canada. With regional advocacy, and with attempts to develop occupational therapy outside a Faculty of Medicine, Dalhousie University in Halifax approved a new occupational therapy program in the Faculty of Health Professions. The first students started in a BSc(OT) program in 1983.[333]

[329] Jecker and Newell, "Occupational Therapists," 267-270
[330] Jecker and Newell, "Occupational Therapists," 267-270
[331] Hudon and Université de Montréal École de réadaptation. *Histoire de l'École de Réadaptation*.
[332] "Dossier de Présentation d'un nouveau programme baccalauréat en ergothérapie" 1975. U545/6/1. Fonds Département d'ergothérapie, Université Laval, Québec City, Québec.
[333] Townsend, Interview.

Depending on the location of the occupational therapy program and the larger faculty it was nested within, occupational therapy program faculty found themselves having significantly different levels of autonomy. Anne Carswell reflected on this level of autonomy when discussing the formation of the University of Ottawa's Occupational Therapy program, which began shortly after the Rehabilitation Era, in 1986. She commented,

> I got involved a lot in the politics of the development because it was a brand-new course and there were a lot of difficulties… there was a lot of difficulties with status and, would we be under medicine, would we be whatever? I spent a lot of time, other than teaching, I spent a lot of time politically within the university to make sure that it became a faculty of Health Sciences and not Medicine under which OT was involved. So that they have their own status within the university.[334]

Carswell discusses the challenges of working within or under Medicine, which motivated her to advocate to be in another area of the university. Depending on the location of the occupational therapy program, in combination with each school's focus, occupational therapy programs found themselves having significantly different experiences in advocacy efforts within the university itself.

The level of advocacy and autonomy within the university was on clear display with the Physical and Occupational Therapy combined program. This combined education occurred at the University of Toronto, McGill University, UBC, and Université de Montreal, with UBC maintaining a combined program for the longest period. After 4 years of a combined P & OT program, McGill changed their program to instead start combined for two years, followed by one to two years, depending on if students wanted to earn a diploma or baccalaureate degree, in either occupational therapy or physical therapy specifically. Graduates from McGill from 1954 onwards earned a diploma or degree in only one discipline, although the first two years remained

[334] Carswell, Interview.

combined until 1971, when two fully separate degree programs were introduced.[335] At the Université de Montreal, physical and occupational therapy separated in 1962, only six years into the program.[336] In contrast, at UBC graduates continued in a combined degree until 1983, when both physical and occupational therapy was offered in distinct degree-earning programs.[337] Rather than graduating students with a combined P & OT diploma however, UBC graduates earned a bachelor's degree of science in rehabilitation. Students did not earn a degree with physical or occupational therapy in the title until the separation in 1983.[338]

Although combined programs were the minority of occupational therapy programs available during the Rehabilitation Era, these programs had a deceivingly large impact on the profession as a whole. Attending a combined program was the only option available east of the University of Alberta until 1965 (in French) or 1967 (in English) for high school students to choose.[339] Canadian healthcare expanded significantly in 1950 through the late 1960s, particularly in rehabilitation, with the increased funding in the post-war years in combination with the transition to publicly funding healthcare. As such, graduates of the combined program often took leadership positions in occupational therapy spaces or were the first occupational therapist hired in a new area. Such a pattern thus directly impacted the entire occupational

[335] "Letter from Isobel Robinson to Hugette Picard-Greffe," 21 July 1988. File B2017-0003/016 (01), Judith F. Friedland Fonds, University of Toronto, Toronto, Ontario.
[336] Hudon and Université de Montréal École de réadaptation. *Histoire de l'École de Réadaptation*; Mémoire de la Corporation professionnelle des ergothérapeutes du Québec présenté à la Commission des affaires sociales à l'occasion de la consultation générale sur les thérapies alternatives, 1993
[337] "School of Rehab Medicine Review, 1982" C 2-12-11. Faculty of Medicine fonds, University of British Columbia Archives, Vancouver, British Columbia.; 1984 Accreditation Report – Occupational Therapy. 151-13. Faculty of Medicine fonds, University of British Columbia Archives, Vancouver, British Columbia
[338]"School of Rehab Medicine Review, 1982" C 2-12-11. Faculty of Medicine fonds, University of British Columbia Archives, Vancouver, British Columbia; 1984 Accreditation Report – Occupational Therapy. 151-13. Faculty of Medicine fonds, University of British Columbia Archives, Vancouver, British Columbia. Meaning, 1983 was the first year of admissions into BSc(OT) and BSc(PT). The last cohort of combined graduates were admitted in 1982 and completed the program in 1985.
[339] This is significant in part because of the concentration of education programs was east of Alberta (and remains so today).

therapy program in a given location. As they progressed through their careers, many P & OT graduates held positions within universities as well, educating students in occupational therapy exclusive programs.[340]

Similarly, individuals working within or associated with the University of Toronto had a significant impact on the development of other occupational therapy programs across Canada. As the original occupational therapy program, other universities would typically consult members of the University of Toronto for guidance and input during the development of their own programs. Nearly all of the English-language programs developed before 1975 have documented interactions with the University of Toronto during the development or initial years of their occupational therapy program.[341] The University of Toronto, meanwhile, continued to offer occupational therapy only as part of a combined program until 1971. Therefore, while P & OT programs ultimately produced the minority of graduates in the Rehabilitation Era, the location and timing of this program had a disproportionate impact on Canadian occupational therapy.

As occupational therapists were striving to remain firmly within a university setting, it became evident that instructors would need to have further education beyond a baccalaureate degree alone. Occupational therapy programs began firmly insisting that their professors have research-focused master's and later doctoral degrees. One notable challenge with such an expectation was the absence of master's or doctoral-level occupational therapy programs in universities.[342]

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[340] Brintnell, interview; Friedland, interview; Townsend, Interview; Cooper, interview; Polatajko, interview; Carswell, Interview; MacKinnon, Interview; Sumsion, interview.
[341] File B2017-0003/016 (01), Judith F. Friedland Fonds, University of Toronto, Toronto, Ontario; File A1981-005-013, 5.26.2. Department of Occupational Science and Occupational Therapy Fonds, University of Toronto, Toronto, Ontario.
[342] Brintnell, interview. The University of Alberta had the first Canadian research-focused master's program in occupational therapy in 1987.

To be at a university level meant, in large part, there are research expectations of your department or school to inform the profession or field. Occupational therapy has, and continues to have, significant challenges in consistently implementing evidence-based practice. While occupational therapy is not alone in this challenge, it is difficult to justify a university-level program with little scientific evidence to support the expertise of a profession. Already feeling at a disadvantage in academia due to the profession's female-dominated staff, occupational therapy programs pushed their professors out of the department and into another in the pursuit of a PhD. Many occupational therapists with a PhD would work in related areas during or following their graduate studies, eventually coming back to occupational therapy. While the lack of a specific graduate program and therefore research base presented in the form of diversity of instruction, it also led to challenges in supporting the assertation that occupational therapy needed to be taught at a university level.

Special Course

A theme spanning much of the literature produced during the 1950s surrounds the incredible shortage of occupational therapists across Canada.[343] Rehabilitation professionals as well as advocacy groups consistently reiterated the demand for rehabilitation services. The subsequent and relatively rapid expansion of the number of education programs was an attempt to meet this demand.[344] CAOT was acutely aware of the shortage of occupational therapists and was highly concerned about occupational therapy positions being replaced by other professions

[343] "Letter from Isobel Robinson to Flora Thompson," 6 December 1985, File B2017-0003/016 (01), Judith F. Friedland Fonds, University of Toronto, Toronto, Ontario. Isobel is writing due to her position as archivist for CAOT; File B2017-0003/015 (10), Judith F. Friedland Fonds, University of Toronto, Toronto, Ontario

[344] *Royal Commission on Health Services: 1964: Volume I*, tabled in the House of Commons on June 19, 1964. https://publications.gc.ca/collections/collection_2016/bcp-pco/Z1-1961-3-1-1-eng.pdf, 61. In 1961, the "Canadian Medical Association suggested a ratio of one occupational therapist per 15,000 population. To meet that standard, 1,200 occupational therapists would have been needed in 1961. In that year membership in the national association was 342, of whom only 319 were providing treatment to patients."

or support-level staff. As a result, CAOT formed a committee in the 1950s to understand the shortages within the profession. Through this analysis, they found there were up to as many vacant positions as there were occupational therapists employed, and unqualified individuals were therefore hired to fill occupational therapist roles.[345]

However, it is not clear that provincial or federal governments shared this sense of concern before the late 1960s. In Ontario, CAOT requested federal funding allocated through the provincial government in 1956 to support the development of *The Special Course in Occupational Therapy*.[346] The course was a specialized, condensed version of occupational therapy training with the clear goal of quickly qualifying more individuals to practice occupational therapy.[347] In their application to the government requesting support, CAOT cited the high demand for occupational therapists and put forward this course as the fastest way to help meet this demand. While the government approved funding in May of 1959, the amount was insufficient to run the program. CAOT assumed a financial burden, with the goal of reducing the occupational therapist shortage.[348] School Director Muriel Driver gave an update on the first 11 months of the Special Course at the 1960 CAOT Annual Conference. There, she commented,

> The Canadian Association of Occupational Therapy sponsors the school which is made possible through the National Health Grants. In short this is a school set up to train personnel to fill the acute shortage of trained occupational therapists. A school that has been created by the profession itself and is being operated by our own association.[349]

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[345] CAOT Report of Psychiatric Committee, Presented at Meeting of Executive Council 13 September 1955. RG 10-22-0-1409, Special Course in Occupational Therapy (Box 86), Archives of Ontario. This committee found 256 OTs working across Canada, and the same number of vacant positions.
[346] Robinson "Muriel Driver Memorial Lecture 1981," 150.
[347] "Letter from Isobel Robinson to Flora Thompson," 6 December 1985, File B2017-0003/016 (01), Judith F. Friedland Fonds, University of Toronto, Toronto, Ontario; File B2017-0003/015 (10), Judith F. Friedland Fonds, University of Toronto, Toronto, Ontario
[348] "Letter from Isobel Robinson to Flora Thompson," 6 December 1985, File B2017-0003/016 (01), Judith F. Friedland Fonds, University of Toronto, Toronto, Ontario; File B2017-0003/015 (10), Judith F. Friedland Fonds, University of Toronto, Toronto, Ontario
[349] "Report June 1960 Vancouver Conference Canadian Association School of Occupational Therapy Kingston, Ontario," 1960, File B2017-0003/015 (10), Judith F. Friedland Fonds, University of Toronto, Toronto, Ontario.

The program rented a house near the university to teach the course, with CAOT being responsible for the cost of rent, utilities, and comparable logistical expenses. During their tenure running the program, CAOT made ongoing appeals to Queen's University to take it over, primarily due to the cost and logistical challenges.[350]

The *Special Course* clearly highlights the tensions between occupational therapists, the public, and broader funding bodies. There is a stated demand in rehabilitation literature, and yet a clear reluctance from others outside of occupational therapy to support expansion of the profession. In 1955, the president of CAOT, Dr. Hoyle Campbell, stated in his President's Address,

> Your executive feels convinced that we cannot wait indefinitely for the establishment of schools for training of Occupational Therapists, and since we are unable to convince others to put them on for us, we have been forced to the opinions that we establish them ourselves.[351]

The statement feels incongruent: how can there be a recognized shortage and need for occupational therapists and yet no interest in generating more occupational therapists? If there was an imminent need for more occupational therapists, then theoretically schools would be open to the idea of establishing a program, or a level of government would be compelled to support such an expansion. Conversely, if schools and funding bodies are not feeling compelled to support an increase in how many qualified occupational therapists are produced, then the shortage must not be negatively impacting society to a degree which would warrant change.

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[350] File B2017-0003/015 (10), Judith F. Friedland Fonds, University of Toronto, Toronto, Ontario. On 9 January 1968, CAOT sent a brief to the federal department of National Health and Welfare drawing attention to the "acute shortage of qualified occupational therapists in Canada." After the program finished, CAOT made a note on the finances of the program, commenting, "In the beginning CAOT loaned approximately $3300 to the course [illegible]. The tuition fees could have presumably covered the expenses. Did we ever get it back?"

[351] Driver, 1981.

In this apparent contradiction lies the root of the issue: education at the university level in occupational therapy was not consistently deemed necessary to fill an occupational therapist role. This concern was compounded by the shortage of qualified occupational therapists, leading to a fear that there could be other paths to solving the occupational therapy shortage, not through a dedicated university program. The Special Course, therefore, reflected CAOT's attempt to meet the shortage with a solution that would not undermine its general educational goal. CAOT was profoundly concerned with this issue and did not feel comfortable in letting the occupational therapist shortage continue as it was thereby not creating any leverage with funding bodies. CAOT ultimately took the approach of starting the program themselves, while continuing to campaign Queen's University to take over running the occupational therapy program. CAOT notes on the program highlighted the end goal, stating,

> There was an ulterior motive in placing the Special Course in Kingston. The anticipation being that eventually Queen's University would become interested and establish a regular programme.[352]

CAOT made ongoing remarks regarding the burden to run such a program, both financially and logistically, while maintaining that it was critical for development of the profession.[353] To their credit, the *Special Course* had lower attrition rates during and after graduation, producing between 10-15 occupational therapists annually and ultimately graduating 76 occupational therapists during their 8-year run.[354]

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[352] File B2017-0003/015 (10), Judith F. Friedland Fonds, University of Toronto, Toronto, Ontario

[353]"Report June 1960 Vancouver Conference Canadian Association School of Occupational Therapy, Kingston, Ontario), 1960. File B2017-0003/015 (10), Judith F. Friedland Fonds, University of Toronto, Toronto, Ontario; Peter Twohig, "Preparing for 'Intelligent and Thoughtful Practice' Occupational Therapy Education in Kingston, 1953-1970." *Ontario History* 116, no. 2 (2024): 200-219. https://doi.org/10.7202/1113340ar

[354] "Occupational Therapy Educational Programmes," 1985, File B2017-0003/016, Judith F. Friedland Fonds, University of Toronto, Toronto, Ontario. There is some debate within archival materials as to the grand total of graduates. There was a note written in pen from the University of Toronto that reports 88 graduates from 59-65 but a typed summary of Occupational therapy in Canada stated 76 graduates (published in 1985). Official presentation at Vancouver Conference stated 11 enrolled in first year. A University of Toronto summary from 1965 reports

The *Special Course* therefore provides a poignant case study in the constant negotiation of professional expertise between rehabilitation and healthcare more broadly, as well as how this negotiation reflected back onto educational program development. With the culmination of World War II, there was a system disturbance created with a significant increase in funding and need of rehabilitation broadly. The *Special Course* demonstrates CAOT's reaction to the perceived threat to jurisdiction created through the system disturbance. With this increased need across healthcare settings came an opportunity for occupational therapy to expand. However, this system disturbance also created the possibility for other professionals to expand their scope of practice to meet rehabilitation needs, running the risk of eclipsing or diminishing occupational therapy expertise. Gritzer and Arluke have demonstrated that many members of the rehabilitation field, including professions such as physiatrists, physical therapists, nurses, and social workers, all felt a sense of threat or attack when it came to occupational boundaries and professional autonomy.[355] Therefore, occupational therapy was not alone in its perception of opportunities and threats during this period.

Over the course of the 1950s and onwards, occupational therapy demonstrated feeling the threats highlighted by Gritzer and Arluke to boundaries and professional autonomy, consistently employing an insular focus in their reaction. While the *Special Course* serves as one example, CAOT was highly focused on education and training, prioritizing these goals over developing relationships with consumers or managerial bodies. Using Freidson's framework, occupational therapy focused on concentrating their professional knowledge and professionalism but did not sufficiently account for concerns of managerialism or consumerism. This is demonstrated by

numbers until 1965 and a question mark for total number of graduates. A letter from Isobel Robinson in 1985 agrees with the 76 number.

[355] Gritzer and Arluke. *The Making of Rehabilitation,* 12.

CAOT taking steps such as creating the Association of Canadian Occupational Therapy University Programs (ACOTUP) and related committees near the end of the decade as a way for the programs to share information and to support each other.[356] The education committee of CAOT also created the outline of Minimum Standards of Training for Occupational Therapists.[357] Actions such as these were valuable for developing the professional expertise of occupational therapists across Canada. However, while they could be referenced in discussion with managerial institutions or consumers, these actions were not specifically focused on communicating with either.

Physical and Occupational Therapy – Are they Similar Enough to be Combined?

For both the lay citizen and many managers within healthcare and academic settings, physical and occupational therapy have traditionally been difficult to differentiate. Each field's scope of practice is similar, at times overlapping, and leads to similar areas of employment. Each profession's guiding philosophy, however, is quite different, with physical therapy's focus historically aligning well with medical goals and medical models of health and rehabilitation.[358]

There were many factors that ultimately led to the creation of combined physical and occupational therapy programs across Canada, although few, if any, of these reasons included desire to combine on behalf of either profession involved. The university or faculty often decided upon merging the two programs with minimal input from either profession in the times leading up to the decision.[359] Rather, in the case of the University of Toronto when considering the move

[356] Cockburn, "Change, Expansion," 3-6; Lynn Cockburn. "The Professional Era," 5-9.
[357] Robinson "Muriel Driver Memorial Lecture 1981."
[358] File B2017-0003/016 (7), Judith F. Friedland Fonds, University of Toronto, Toronto, Ontario; McGavin, interview; Townsend, interview.
[359] Isobel Robinson, interviewed by Judith Friedland, B2017-003, Box 006, file 17, Judith Friedland Fonds, University of Toronto Archives. Technically, both occupational therapy and physiotherapy were consulted (at least at the University of Toronto), but and most input came in negotiations in how to combine them, after the decision had been made. Pp 62.

towards a combined program, male physicians claimed that occupational therapists and physiotherapists were "girls who could do both."[360] For the University of Toronto, the P & OT program was born out of two individual programs, although the length of the combined program remained the same as each individual diploma had previously run. This resulted in each profession having to cut significant portions of their respective curriculums.[361] In an oral history interview completed with Judith Friedland, Isobel Robinson shared that the combined program led to competition between the occupational therapists and the physiotherapists. She reflected on the sense of helplessness the two programs felt as physicians at the University of Toronto pushed for their combination. She reflected, "the doctors seemed to have control. They were the ones that wanted the combined program. No OTs or PTs particularly."[362] P & OT programs tended to focus more heavily on physical therapy, as physical therapy had a clearer alignment with the perspective of the physicians running the faculty and attracted more students than occupational therapy. The focus towards physical therapy concepts left occupational therapists significantly aggrieved.[363] Occupational therapists as well as professional representatives felt that a combined program gave insufficient time to adequately educate on the full scope of occupational therapy, resulting in too many compromises on which subjects to teach to occupational therapy students.[364]

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[360] Helen LeVesconte, interviewed by Valerie Schatzker, B2017-003, Box 011, file 4, Judith Friedland Fonds, University of Toronto Archives. Helen reported that neither occupational therapy nor physiotherapy was asked in advance of combination, and rather that physicians wanted a person who could fill both roles.
[361] Isobel Robinson, interviewed by Judith Friedland, B2017-003, Box 006, file 17, Judith Friedland Fonds, University of Toronto Archives.
[362] Isobel Robinson, interviewed by Judith Friedland, B2017-003, Box 006, file 17, Judith Friedland Fonds, University of Toronto Archives. Technically, both occupational therapy and physiotherapy were consulted (at least at the University of Toronto), but and most input came in negotiations in how to combine them, after the decision had been made. Pp 62.
[363] Isobel Robinson, interviewed by Judith Friedland, B2017-003, Box 006, file 17, Judith Friedland Fonds, University of Toronto Archives. Physiotherapy programs also did not enjoy the combined program, as they too felt a single program was needed for adequate education.
[364] Isobel Robinson, interviewed by Judith Friedland, B2017-003, Box 006, file 17, Judith Friedland Fonds, University of Toronto Archives.

In her experience attempting to combine occupational therapy with physical therapy at the University of Toronto, Helen Levesconte consistently spoke of the challenges she faced attempting to pare occupational therapy education down to a point of fitting in with the new three-year combined diploma program. Levesconte was the director of the occupational therapy component of the combined program at the University of Toronto.[365] In various instructional capacities she educated over 1,850 students spanning 33 years before her retirement in 1967.[366] In letters to colleagues and friends she frequently lamented on the challenges of finding what components of occupational therapy were most important to keep in the classroom and which of these components were able to be taught with physical therapists.[367]

Occupational therapy classes within a combined program often focused on crafting and mental health; two major distinctions from physical therapy. Many courses such as anatomy and physiology were labelled as core courses that were valuable for both professions. However, these courses felt more akin to physical therapy for many students as physical therapy drew more explicitly on the material.[368] For example, physical therapy courses would instruct how to complete exercises to help heal injured muscles, as understood from anatomy. A lecturer could easily reference anatomical names from a core course, highlighting the physiological injury and rehabilitative pathway to heal the injury. In contrast, occupational therapy courses would complete activities such as crafting projects, which were not as clear in their ties to the core courses as these activities were focused on productivity and meaning.[369] It is not clear how

[365] Juliette (Archie) Cooper, interviewed by Katie Lewis, Zoom (Winnipeg and Hamilton), 22 September 2023.
[366] Friedland and Rais, “Helen Primrose LeVesconte,” 131-141; Driver and Robinson, "Tribute Helen P. LeVesconte," 103-105.
[367]Juliette (Archie) Cooper, interviewed by Katie Lewis, Zoom (Winnipeg and Hamilton), 22 September 2023; Elizabeth Townsend, interviewed by Katie Lewis, Zoom (Halifax and Hamilton), 23 June 2023; Martin, Interview.
[368] Townsend, Interview.
[369] Townsend, Interview; Cooper, Interview.

basket weaving, for example, relates specifically to anatomy, as anatomical function is one of many rationales for the completion of this activity. In some cases, though, occupational therapy activities would be specifically tied to anatomical injuries to align more strongly with the combined course program and therefore fit within medical models. Meaning, occupational therapists would start with an injury, find a craft that used muscles or positioning that could improve the injury, and then assess the effectiveness of the craft project through how much physical recovery occurred within the individual. However, occupational therapists regularly felt uncomfortable with this approach as well, given that such an approach did not align with occupational therapy theories or philosophies.[370]

Rather than matching an injury to a craft and measuring success in terms of physical change, occupational therapy philosophy would be focused upon meaning and purpose as metrics of change. This would mean, that while an individuals' degree of shoulder abduction may not increase, if they were able to return to meaningful activities and participate in their daily lives, they would be achieving success from an occupational therapy point of view.

Archie Cooper reflected on how uncomfortable and confusing it was to be combining occupational therapy with a more physical therapy way of thinking, stating,

> I can remember trying to analyze weaving so that people had the maximum abduction when they were weaving. Everything was just insane; it was really crazy. And so, I think we really lost sight of occupation, and we were into some kind of weird exercise.[371]

The initial use of basket weaving, and related activities, had not been created with considerations of abduction or other active range of motion. Rather, weaving and similar therapeutic methods were created to meet the twofold goal of a diversional activity that had the potential to earn some

[370] Friedland, interview; Cooper, interview; McColl, Interview.
[371] Cooper, interview.

form of income.[372] This goal evolved into more explicitly considering meaning for the client, with the theory that participating in meaningful occupations of the time had therapeutic value. The concept of occupation, as Cooper refers to, is concerned with an activity that is meaningful and engaging to the individual; should these criteria be met then occupational therapy is achieving what it should be. Changing the goals of an activity to reflect physical results, such as in the example above with shoulder abduction range of motion, made the ties to "core" courses in the P & OT program clearer; however, this clarity came at the expense of the logic underlying the activity from an occupational therapy perspective to begin with and therefore the goal of occupational therapy itself.

Part of the challenge of arguing against contorting occupational therapy methods into physical therapy goals was the absence of scientific research based in occupational therapy or occupational science. Prior to the 1980s, there was limited research completed specifically in occupational therapy. Further, there were few, if any, theories of practice or models for occupational therapists to draw upon in practice. As occupational therapy research was in its infancy, it was challenging to empirically argue against physical therapy methods and the medical model. At this time, occupational therapy programs were located within Faculty of Medicine or similar areas within a university. As such, occupational therapy needed to be drawing upon research if the profession was to be able to make a case for separation.

Although there was a general sense of dissatisfaction with the number of occupational therapy-focused graduates produced from P & OT programs, there was also a benefit of a notable number of students in the program who had not heard about occupational therapy or did not enjoy occupational therapy education as a student, yet ultimately did pursue careers in

[372] Friedland, *Restoring the Spirit*, 142, 144.

occupational therapy.[373] Adele Martin, a P & OT gradate from the University of Toronto recalled her experience in the program, stating,

> I think that, from my perspective, going through that program, I felt a little more attached to the physiotherapy side, than I did to the occupational therapy side. And I think it's because the physio side tended to be more relatable. To movement and my understanding, you know sort of developing and understanding the role. Whereas occupational therapy at the time. Oh gosh it… It, it tended to be really focused on mediums.[374]

Her experience is echoed in other recollections of the P & OT program, with students typically being drawn to occupational therapy only if they happened to enjoy crafting or psychiatry.[375] Her reference to mediums refers to crafting based activities, ones unclearly tied with physical therapy goals at the time. Based on her experience in the P & OT program, Martin chose to pursue employment in physical therapy, only switching to occupational therapy when her family moved to an area that did not have any physical therapy jobs available.

Liz Townsend, one of the leaders in Canadian occupational therapy during the Rehabilitation Era, recalled those who leaned towards occupational therapy in her class, "I think the people who initially chose occupational therapy saw it as a creative profession in which they could use their craft knowledge in a health-related area."[376] Liz recalled choosing to pursue an education in physical therapy and discovering occupational therapy when she began at the University of Toronto,

> I chose physiotherapy, and to my surprise it included this, what I had never heard of before: Occupational therapy… And as I went through the three-year program, I learned quickly that occupational therapy was the poor sister of physiotherapy. When you're in a program where most of the courses are active and engaging and so forth, and they relate to physiotherapy and the other courses were handcrafts, primarily weaving and sewing and all that sort of stuff, none of which I was interested in or good at.[377]

[373] Cooper, Interview; Townsend, Interview; Adele Martin, interviewed by Katie Lewis, telephone, 1 September 2023; McColl, Interview.
[374] Martin, Interview. Mediums refers to using crafting type objects to promote wellness and participation.
[375] McColl, interview; Oral history thematic analysis, 2023.
[376] Townsend, interview.
[377] Townsend, interview.

Townsend's experience reflects the uncomfortable union between occupational therapy and medical models. While the University of Toronto had decided that occupational therapy could be instructed in such a way to merge with physical therapy, the lived experience of the program made it clear that these two professions were not in fact particularly compatible. Though not as explicit as Cooper's recollection, Townsend and Martin further demonstrate the impossibilities of merging occupational therapy methods with a physical therapy knowledge base. The end result was crafting courses that felt useless, difficult, and lacking strong ties to value in practice. Those naturally inclined in crafting, or that had seen occupational therapy practiced outside of school, however, were more able to see the value in occupational therapy and were therefore more likely to pursue it as a career.[378]

The students who entered the combined program looking to pursue occupational therapy, the minority of applicants, were often those who had stumbled upon it in a career book or had a family member who worked as or with occupational therapists. Cooper enrolled in the University of Toronto's P & OT program with full intention of becoming an occupational therapist. Speaking of her decision to pursue occupational therapy, she recalled,

> My aunt was an occupational therapist… she really wore that OT identity, so as I grew up, it was very evident to me that Auntie May was an occupational therapist. When I was about 16, the question was, well, what's Archie going to do for the rest of her life?... at the time my aunt was the director of OT at Queen Mary Veterans Hospital in Montreal... I went into the department, and, my goodness, it was a hive of activity. There were all kinds of men because they were veterans. They were all they were doing, weaving, basketry, pottery… anyway, they were all very active, and they all seem very engaged. So, I thought, well, that sounds pretty good. I would really like to do that.[379]

Despite entering the program with knowledge of the occupational therapy role and having a family member who was a proud occupational therapist, even Cooper questioned her decision to

[378] Cooper, interview; McColl, interview; Harper, interview; Etcheverry, interview.
[379] Cooper, interview.

pursue occupational therapy, stating, "By the end of year two I was convinced that I wanted to be a physiotherapist."[380] The experience of the combined program had changed her desire of pursuing occupational therapy. For Cooper, it was the placement experiences, rather than the classroom education, that ultimately inspired her decision on what profession to pursue.[381] After not enjoying a physical therapy placement and being inspired by an occupational therapist lecturer that worked at a nearby hospital, Cooper took an occupational therapy position upon her graduation. Cooper, capturing the sentiment of many other P & OT trained occupational therapists, shared that,

> When you're in it, you don't know any better. Right? So, to me doing half OT and half physio made some kind of sense I felt, though, once I started practicing, and I was practicing mental health, there were big islands, I thought, that had been missing… There was no way that you could pack everything you needed to know about OT into half of 3 years, you know it's just not very possible… I had excellent teachers. We just didn't have enough time to do what I thought at the time was needed.[382]

Cooper ultimately went back to her plan to become an occupational therapist, and "never did practice as a physiotherapist at all."[383] Reflecting on the combined program, she felt that the "combined program was just dumb... What a stupid idea!"[384] Her trajectory of experiences is similar to many other occupational therapists who did not necessarily enjoy the educational components of the P & OT program or feel they were fulsome but were inspired by other occupational therapists themselves and enjoyed the role once they were in practice.

The negative experience many students had in the occupational therapy component of P & OT programs impacted more than the numbers of occupational-therapy-focused graduates.

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[380] Cooper, interview.
[381] Cooper, interview. "I did a field work placement at what was then called the Ontario Cripple Children Center, and it was a Physio placement, and I did exactly the same thing with exactly the same child, for 8 weeks, and I was bored stiff. I thought, nope, I can't do this."
[382] Cooper, interview.
[383] Cooper, interview.
[384] Cooper, interview. She went on to say, "and you can quote me on that!" accenting her strong feelings on the subject.

This "poor sister" image had a formative impact upon the students, often factoring into perceptions of value and worth.[385] Through attending an educational program that clearly favoured one discipline over the other, P & OT graduates often had challenges defining the occupational therapist identity outside of a relationship to physical therapy. However, while many occupational therapists shared a negative sentiment of the educational experience of a combined program, many P & OT graduates regularly practiced in whichever role happened to be available in a desired location. These dually trained therapists would also often switch back and forth, and frequently use the full scope of their education in whichever role they officially held until licensing costs ultimately made P & OTs commit to one field.[386]

In the case of Martin, she took a role as an occupational therapist only after being informed there were no physical therapy openings in her desired location of employment. When taking the occupational therapy role on, she recalled,

> I really felt I'm going to take up the challenge and move forward, but I had no intention of staying in OT, at all. I thought, OK, I'm gonna do this for a year, maybe two, get my feet wet, and I'm going right back into physio and that wasn't the case… I began to understand and appreciate the professional practice and what it had to offer the client. It just made so much sense that I should stay in this practice.[387]

Her experience in the P & OT program was far from unique and demonstrates the complicated experience of occupational therapy in defining its place in education and in healthcare systems.[388] Martin, along with others, had not been drawn to occupational therapy over the course of the program, in particular due to the crafting experience. This experience, however, was not representative of the career of occupational therapy, in part due to artificially created ties to the physical therapy knowledge base. On paper, as occupational therapists were frequently

[385] Townsend, interview.
[386] McGavin, Heather. Interview by Katie Lewis. August 22, 2023.
[387] Martin, Interview.
[388] Penny Salvatori, Interview by Katie Lewis. July 7, 2023; Townsend, interview.

employed in hospital systems and worked with individuals with disabilities, the profession appeared quite similar to physical therapy. This perceived similarity in turn inspired the combination of occupational with physical therapy in an education setting focused on the medical model. This false sense of compatibility emanated from those in managerial positions, be it within healthcare or academic settings, but not from either the physical or occupational therapists. Common perception of the high similarity between occupational and physical therapy, in combination with limited societal understanding of occupational therapy, often did not change until an individual practiced occupational therapy itself and felt the difference. As Martin's experience highlights, when working with patients as an occupational therapist, individuals truly began to appreciate the nuanced differences between occupational therapy and physical therapy.

The precise essence of occupational therapy has been difficult to define or capture. The lived experience of practicing occupational therapy did not consistently align with medical models or physical therapy, nor were educational programs able to adequately capture what would be the practical experience of working as an occupational therapist. Many graduates of both the P & OT program and occupational therapy specific programs felt that their education in occupational therapy did not align with their careers as an occupational therapist.[389] There are a wide variety of reports of satisfaction with either type of program, however, a consistent theme spanning the majority of recollections is that placement experience was the true predictor of occupational therapy career satisfaction.[390] The classroom learning components often did not sufficiently relate to individuals' experiences as a practicing occupational therapist. In contrast,

[389] Brintnell, interview; Cooper, interview; Friedland, interview; McGavin, interview; Salvatori, interview; Townsend, interview.
[390] Brintnell, interview; Cooper, interview; Friedland, interview; McGavin, interview; Salvatori, interview; Townsend, interview.

physical therapists do not report nearly as much of a mismatch between their education and their careers.[391]

Such a mismatch between education and career experience is clearly explained by graduates from the P & OT program, as occupational therapy methods were contorted to fit into a physical therapy and medical model method of practice. However, graduates of a dedicated occupational therapy program, receiving either a bachelor's degree or a university diploma, also frequently reported dissatisfaction with the educational program before having significant satisfaction in their occupational therapy career itself.[392] Emily Etcheverry, who obtained a Diploma in Occupational Therapy from the University of Manitoba, commented on her educational experience,

> [in the occupational therapy program] There were things that I didn't like. I think the OT content was pretty small. When I think about the content that I ended up living and teaching… our OT content, was primarily learning about the different crafts and different things that you would do. We did weaving. We did basket making. We did stool making. We did printing... but I always enjoyed all of those things. We had one textbook, I think that was an OT textbook and we had not a lot of what I would call any good content that linked what we were doing to how we would use it in a practical sense… It wasn't bad, it's just the OT content wasn't very much or very good… there was a very strong physio dominance in the in the program at the time.[393]

Completing her diploma in the early 1970s, she echoes a similar experience as P & OT graduates had in the 1960s. Although the University of Manitoba had never offered occupational therapy as a combined program, physical therapy was still present due to the organizational structure of the University of Manitoba. While not all Canadian-trained occupational therapists had graduated from a combined program in the 1960s and 1970s, at least some still felt the strong influence of

[391] McGavin, interview.
[392] Etcheverry, interview; Harper, interview.
[393] Etcheverry, interview.

physical therapy.[394] The experience of non-P & OT programs speaks to one of the challenges for the profession. For occupational therapy, the accommodation to the medical model was consistently difficult. However, CAOT insisted on an educational model that placed occupational therapy education within medical schools and therefore within the medical model and the university research model. CAOT insisted on this educational standard in large part due to the pursuit of creditability, demonstrating in part the enduring influence from physicians. While being within a university improved the perceived legitimacy of occupational therapy, the position within universities frequently led to significant compromises on the guiding principles to occupational therapy education.

Throughout the Rehabilitation Era educational programs, both combined and individual, encountered challenges navigating how to run a program that properly prepared individuals for a career in occupational therapy. Occupational therapists employed in university programs attempted to navigate several factors, including the hierarchies of education, gender dynamics, the realities of employment opportunities, developing occupational science and research, and ongoing challenges with forming a coherent identity. These challenges resulted in the negative experiences of students in the occupational therapy component of P & OT programs especially, in addition to the critiques of occupational therapy specific programs.

As both educational programmes and employment opportunities in healthcare were expanding rapidly during the Rehabilitation Era, there were frequent challenges in adequately aligning education for practice. The interplay between significant factors such as the growth of the profession, changes in scope of practice, and insecurity around professional identity

[394] Sometimes the medical model felt like a physiotherapy influence. Occupational therapy may not have been specifically influenced by physiotherapy in those moments, but the medical model and physiotherapy got convoluted in memory or actual experience due to the overlapping principles.

compounded and enabled the ongoing dissatisfaction with occupational therapy education. The significant differences reported from occupational therapists between their occupational therapy education, placement experience, and work experience as an occupational therapist highlights the challenges in developing a consistent understanding of the precise role of occupational therapy.

Here, the relationship of occupational therapy with supervisors, as defined by Abbott and Friedson, in the workplace plays a clear role in definition of scope. As occupational therapy was attempting to differentiate itself from physical therapy, it was attempting to do so in a climate that was continuously adding roles in new areas of practice. As a profession with a fragile identity and deep-rooted fears of becoming extinct or downgraded within the healthcare hierarchy, occupational therapy was quick to move into new areas of practice. However, in this period of professional expansion, occupational therapists as a collective had challenges centering the role as a distinct profession with a specific scope of practice. Occupational therapists strongly advocated for the dissolution of the P & OT programmes, in large part to help cement their identity as a unique profession with specific expertise to offer, distinct from physical therapy.[395] While the goal of dissolution was achieved in the 1970s, the larger goal of asserting an independent and understood identity was not fully realized. As professions in healthcare requiring expertise, both physical therapy and occupational therapy professionals wanted a program that was specifically focused on each of their respective areas of practice. Mutual advocacy from both professions had supported the dissolution and discontinuation of P & OT programs. However, as physical therapy had been the more understood, focused upon, and popular choice throughout its years in the P & OT program, the profession continued to be better understood by the lay public moving forward throughout the Rehabilitation Era.

[395] Sharon Brintnell, "From the President's Desk" *Canadian Journal of Occupational Therapy*, Vol 46, pp 1-8; Sharon Brintnell, interviewed by Katie Lewis, Zoom (Edmonton and Hamilton), 24 July 2023.

Other factors, in addition to the desire to separate from physical therapy, led to the dissolution of P & OT programs. Many graduates felt that a diploma was not a reasonable level of education for the work completed upon graduation as well as the difficulty level of the program itself.[396] When the new occupational therapy and physical therapy programs were created, they were done so at the baccalaureate level.[397] CAOT advocated for the entry to practice level of education to be at the degree level, and in 1971 created a policy that a baccalaureate degree was the basic level for entry to practice.[398] Their desire for a higher level of education had become much stronger against external pushes for an occupational therapy program to be started at the college level at Mohawk College in the late 1960s.[399] Graduates of the P & OT program themselves also felt disappointed to have earned a diploma while peers in other programs earned a degree for seemingly comparable endeavours.[400] When asked about her experience in the P & OT program at the University of Toronto, Cooper shared,

> Well, it was very challenging, and I have to say I felt completely ripped off at the end of 3 years, and only getting a diploma cause, I thought, excuse me, we have worked very hard. It was challenging program.[401]

Many graduates of the P & OT programs, especially from McGill University, UBC, and the University of Toronto, ended up taking courses working towards a degree completion program.[402] These individuals chose to do so before a degree was officially recommended or

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[396] Cooper, interview; Friedland, interview; oral history thematic analysis, 2023.
[397] "Letter from Isobel Robinson to Hugette Picard-Greffe," 21 July 1988, File B2017-0003/016 (01), Judith F. Friedland Fonds, University of Toronto, Toronto, Ontario.
[398] "Annual Report of C.A.O.T Committee on Standards and Accreditation of Educational Programs," 1972, File B2017-0003/016 (07), Judith F. Friedland Fonds, University of Toronto, Toronto, Ontario; "Notes from Files on Accreditation, Education C.M.A & C.A.O.T," 15 February 1971, File B2017-0003/016 (07), Judith F. Friedland Fonds, University of Toronto, Toronto, Ontario.
[399] Brintnell, interview; "Annual Report of C.A.O.T Committee on Standards and Accreditation of Educational Programs," 1972, File B2017-0003/016 (07), Judith F. Friedland Fonds, University of Toronto, Toronto, Ontario; "Notes from Files on Accreditation, Education C.M.A & C.A.O.T," 15 February 1971, File B2017-0003/016 (07), Judith F. Friedland Fonds, University of Toronto, Toronto, Ontario.
[400] Cooper, interview; Townsend, interview.
[401] Cooper, interview; Friedland, *There Was a Time*.
[402] Oral history thematic analysis, 2023.

required by licensing bodies. However, the desire was not shared by all P & OT graduates. Barbara Barr reflected on her decision-making process concerning participating in a degree completion program, stating,

> I looked at it, it was offered at U of T- these are the days before computers and there was no online [option], I would have had to travel from Peterborough to Toronto to take the courses. I looked at the courses and I thought what I would really like to take is statistics. I would like to have a better background in statistics, but the other courses, I did not think they would make me a better clinician… so I didn't. I didn't do the degree completion because I didn't think it was going to make me better… there was nothing to do with occupational therapy, so I didn't.[403]

Barr further reflected that at no point in her career did she find her diploma held her back or led her to pale in comparison to other practicing occupational therapists, even after a degree became mandatory for entry to practice. Barr instead participated in as many professional development courses as she could, related to her area of practice at the time.[404] The common experience between occupational therapists who chose to upgrade their diploma and those who chose not to, was the understanding that a diploma was not an accurate representation of the education provided. Those who upgraded their diploma for a degree did so while feeling a degree was more representative of their efforts. Those who chose to keep their diploma only did so as they felt their education was comparable and sufficient when compared to those with a degree. Further, both groups felt strongly that work experiences in the field were the most valuable experience in improving their skills in occupational therapy.

Importantly, the structure of the combined P & OT programs demonstrates the appreciation of occupational therapy's scope of practice from managerial bodies. The University of Toronto's decision to initiate a combined course, with no additional time added, speaks to the limited understanding or appreciation of each field's scope on behalf of those choosing to

[403] Barr, Interview.
[404] Barr, Interview.

combine the two programs. A combined program did not accurately reflect the difficulty level, value of the complete course work, and full scope of practice for either occupational or physical therapy. Further, as the profession with the minority of graduates, occupational therapists felt that they experienced worse outcomes from the combined program than physiotherapists. Occupational therapists who graduated from a P & OT program shared their lived experience of attending further education after graduation to develop skills that had not been addressed in the P & OT program, searching for mentorship, appreciating occupational therapy only after a placement or work experience, and the career-long need to explain how their own role and scope of practice was different than physical therapy to non-occupational therapists.[405]

The "Problem" of Mohawk College

The *Special Course* in Kingston was not the only training program in Canada which took a different approach to occupational therapy education. Looking to solve a similar issue as CAOT attempted to with the *Special Course*, the provincial government took a different approach to increase the number of occupational therapists in Ontario. By the mid 1960s, the government of Ontario was in agreement with concerns highlighted by CAOT that there was an insufficient supply of occupational therapists to meet provincial needs.[406] However, the government felt differently than CAOT on one main point: that occupational therapy education had to be completed in a university setting. Unlike CAOT, the province of Ontario also needed to consider the post-secondary educational needs of all residents and were concerned about the

[405] Oral history thematic analysis, 2023. The experience also hindered the development of a professional identity and secure sense of self as a profession.
[406] Evans Papers: Hamilton Health Association, Occupational Therapy Advisory Committee, Mohawk College of Applied Arts and Technology, 1968-69. McMaster University, Health Science Library Archives, Hamilton, ON.

significant population increase impacting availability of post-secondary education.[407] Seeking to meet the demand and train practical therapists, acknowledge regional needs in Hamilton, and take into consideration the constraints on university enrollment, the Ontario government, CAOT, McMaster University representative, Mohawk College representative, and the Chedoke hospitals began to explore an occupational therapy program at Mohawk College in 1968.[408]

At the federal level, there was a national recognition of the increased need for post-secondary education generally across disciplines.[409] The Technical and Vocational Training Assistance Act of 1960 was a component of the national response, which provinces each utilized differently to create college-level education. Each province outlined different relationships and distinguishing features between universities and college. In the case of Ontario, the province created the Colleges of Applied Arts and Technology (CAATs) in 1965. CAATs were clearly delineated from universities, with highly regional goals in their educational output. Essentially, the goal of Ontario colleges was to meet local labour needs, with therefore a significant local presence in each Ontario college. This local responsiveness was also intended to address the challenge in meeting such an increase in need for undergraduate programs, recognizing the needs for an increased variety and overall ability of post-secondary education for Ontarians.[410] Importantly, CAATs "were designed to provide training for a variety of technical personnel," a notable difference from the goal of university education.[411]

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[407] Evans Papers: Hamilton Health Association, Occupational Therapy Advisory Committee, Mohawk College of Applied Arts and technology, 1968-69. McMaster University, Health Science Library Archives, Hamilton, ON.; Twohig ""Everyone Knows There is a Battle," 95-116.
[408] Twohig ""Everyone Knows There is a Battle," 100; Evans Papers: Hamilton Health Association, Letter to Mr. Stevel Trujillo from Dr. John C. Sibley, 23 March 1981. McMaster University, Health Science Library Archives, Hamilton, ON.
[409] *Royal Commission on Health Services: 1964: Volume I*, tabled in the House of Commons on June 19, 1964. https://publications.gc.ca/collections/collection_2016/bcp-pco/Z1-1961-3-1-1-eng.pdf
[410] "Statement by Hon William G. Davis in the Legislature," 21 May 1965. MG28-I495, 123-020062-2, Box 17, Mohawk 1983, CAOT Fonds, National Archives, Ottawa.
[411] Twohig ""Everyone Knows There is a Battle," 100.

In the context of the 1960s in Ontario, there were significant needs across healthcare disciplines. The initiation of publicly funded healthcare, advances made in medicine and technology allowing more individuals to live with physical disabilities, as well as the significant increase in rehabilitation and psychiatric needs arising from World War II, led to far more healthcare job vacancies than could be filled by educational programs available at the time. In pursuit of solving this issue, the Ontario government established the Committee on Healing Arts in 1966.[412] This committee considered more than fifty disciplines over the course of four years, ultimately making over 200 recommendations related to a variety of healthcare disciplines. According to committee findings, the development of health care worker education in the context of this significant expansion had not occurred with sufficient planning, leading to regional shortages of qualified practitioners. Healthcare at the university level was expensive and time consuming, clearly not meeting Ontarian's needs in the process. To address local needs and expedite education at a lower cost, the Healing Arts Committee recommended that healthcare education pathways become more flexible. One such path to flexibility and efficiency was to train some healthcare workers with sufficient background knowledge to then "consolidate their skills through practical experience in his or her chosen occupation."[413]

The Healing Arts Committee considered occupational therapy specifically. One recommendation concerning occupational therapy was that the entire role of occupational therapists did not need to be completed by an occupational therapist specifically. The committee found "some components of occupational therapy which in certain situations can be carried out

[412] Ruby Heap, "Physiotherapy's Quest for Professional Status in Ontario, 1950-80." *Canadian Bulletin of Medical History* 12, no. 1 (1995): 69-99.
[413] Twohig ""Everyone Knows There is a Battle," 101.

by persons other than qualified occupational therapists."[414] With this recommendation, the Healing Arts Committee took a clear stance that occupational therapy roles could be divided in two, whereby university-trained occupational therapists would fill certain aspects and a "second level of therapist" trained at the college level could fill remaining aspects of the role. The report did not find, nor complete research into the specifics of a second level therapist role, recommending that occupational therapy as a profession could examine this area further.

As CAOT's challenges with getting Queen's University to take over running the *Special Course* highlighted, there were no easy paths into increasing the number of university occupational therapy programs in Ontario. Disability organizations, among other groups, were simultaneously highlighting the need for more occupational therapists across Ontario.[415] From the perspective of the Ontario government, Mohawk College served as an ideal solution to the provinces needs of more educational options for occupational therapists, both from a professional needs perspective as well as a way to meet the increased post-secondary education demands. By the late 1960s, Hamilton was an established medical town, with the Henderson General Hospital and Chedoke Hospital, further cementing Mohawk College as a viable option.[416]

[414] Twohig ""Everyone Knows There is a Battle," 100-101. "The Committee does not wish to see the public deprived of the usefulness of these persons as they appear to perform a useful service."
[415] Evans Papers: Physical Medicine and Rehabilitation, 1966-70. McMaster University Health Sciences Archives, Hamilton, ON.
[416] Evans Papers: Physical Medicine and Rehabilitation, 1966-70. McMaster University Health Sciences Archives, Hamilton, ON. The Henderson General Hospital was a combination of the Hamilton General Hospital, the convalescent hospital, and the mount Hamilton Hospital. Chedoke was an evolution of the Mountain Sanatorium and was a center for children's rehabilitation. By 1970, "Chedoke" was officially the Chedoke-McMaster Centre, operated by the Hamilton Health Association in conjunction with the Division of Health Sciences McMaster University.

Initially, CAOT appeared to be on board with the idea of Mohawk College running an occupational therapy program. In a letter to Dean John Evans from Dr. J.C. Sibley in late 1968, he wrote,

> The Ad Hoc Committee meeting with the representatives from the Canadian Association of Occupational Therapists, Mohawk College, McMaster University and The Hamilton Health Association was held earlier this week. Everything proceeded very smoothly, they have agreed to ask Mohawk College to set up an on-going Advisory Committee in Occupational Therapy as had been done in Physiotherapy. I don't foresee any difficulties, and we should be able to move ahead fairly quickly into attempting to define the role of the occupational therapist and then curriculum planning. With luck we might be able to consider September 1970 as a possible opening date.[417]

However, CAOT soon changed its position on approval of Mohawk College. CAOT's principal point of objection was that the Mohawk College program would not require completion of grade 13 to be admitted. However, the requirement of grade 13 spoke to a broader concern occupational therapy representative had with the level of education required to practice occupational therapy. In a letter to Ontario government, criticizing the start of the Mohawk College program, Steve Trujillo stated,

> Protest by the occupational therapy organization was based on their firm commitment that quality university education was the fundamental educational requirement for attaining occupational therapy qualifications.[418]

In 1969, every other education program in Canada was run at the university level, although not all were offering bachelor's degrees.[419] While initially open to dialogue with the provincial government as well as Mohawk College in the development of an occupational therapy program, CAOT soon decided that a university setting was the only appropriate location for an

[417] Evans Papers: Occupational Therapy, 1968-72. McMaster University Health Sciences Archives, Hamilton, ON. "Excerpt of Memorandum, December 20, 1968."
[418] Letter to Honourable Dr. Bette Stephenson from Steve Trujillo, 18 February 1981. Faculty of Health Sciences Fonds, Rehabilitation Science, Administration, Box 1. McMaster University, Hamilton, ON.
[419] There were two university level diploma programs when this program was first proposed. The University of Toronto and Queens University were both diplomas, with the University of British Columbia having a diploma option. There were concrete plans to replace all three into degree programs.

occupational therapy program. As stated in their "Position Statement on Undergraduate Education,"

> The provision of professional education is an important part of a university's mandate, a position the Association has strongly supported since its inception in 1926. The Association believes that the level and quality of occupational therapy research and practice differ when therapists are not educated in a university setting…. The university setting provides the intellectual foundations for professional practice.[420]

CAOT continued doubling down on this standard as they were met with increased pushback and disregard from the provincial government. At the time of first discussion of the possibility of an occupational therapy program at Mohawk College, the education standard across Canada was in the process of moving from university diplomas into university baccalaureate degrees, with all university programs becoming degree programs by 1971.[421] While degree completion was not mandatory for diploma graduates after the change, CAOT was keen to have the profession remain at the university level and solidify the degree designation. By the time Mohawk College finally began their inaugural cohort of occupational therapy students in 1977, CAOT was firmly and publicly in opposition of the program, deeming Mohawk College graduates ineligible for CAOT membership.

The Mohawk College program began nearly a decade after first planning began, in large part due to the extensive pushback from CAOT. Ultimately, the Mohawk program was not created specifically on a recommendation of the Commission on the Healing Arts, "but it was in keeping with the thrust of that report."[422] In part due to challenges for Mohawk graduates, McMaster University began to allow occupational therapy graduates from Mohawk college to

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[420] H. Madill and M. Brockett. "Position Statement on Undergraduate Education." *The Canadian Journal of Occupational Therapy* 54, no. 4 (10, 1987): 2-3. https://doi.org/10.1177/000841748705400401

[421] Cockburn, "Change, Expansion," 3-6. Degree completion was not mandatory for diploma graduates after the change.

[422] Letter to Steve Trujillo from Dr. John C. Sibley, 23 March 1981. Faculty of Health Sciences Fonds, Rehabilitation Science, Administration, Box 1. McMaster University, Hamilton, ON.

enrol in a B.H.Sc. program. This was optional, but did not appease occupational therapy representatives. Trujillo stated, in frustration that the Ministry of Colleges and Universities had approved the program,

> The question must be asked - Is Mohawk College an extension of McMaster University or is McMaster just a deluxe edition of Mohawk College? This and other questions must be answered by the Ministry of Colleges and Universities. What makes a university distinct from a community college? Is it philosophically and educationally defensible that grade twelve students can enter a community college program and receive credits which, when combined with a three course thirteen-week enrolment at McMaster University, provides them with a Bachelor of Health Sciences degree? Does not the Ministry of Colleges and Universities and the Government of Ontario respect a university education and desire to maintain its credibility?[423]

McMaster University stood by the decision to allow diploma graduates an opportunity for a condensed degree completion program. Their support came, in part, due to McMaster's role in the Mohawk diploma program. McMaster provided a "very significant academic and teaching resource in the Mohawk programme."[424] Nonetheless, CAOT refused to recognize Mohawk graduates as eligible to register as occupational therapists, maintaining their position that occupational therapy must be taught at the degree-level for the duration of the program.

Given this contentious climate, Mohawk College graduates had significant difficulty finding employment upon completion of their course. This was not due to their skillset, as it was consistently described as comparable or superior to university graduates.[425] In fact, through the use of problem-based learning and a heavy emphasis on theory, Mohawk graduates were well-prepared to work as occupational therapists.[426] However, CAOT's refusal to recognize Mohawk

[423] Letter to Honourable Dr. Bette Stephenson from Steve Trujillo, 18 February 1981. Faculty of Health Sciences Fonds, Rehabilitation Science, Administration, Box 1. McMaster University, Hamilton, ON.
[424] Letter to Steve Trujillo from Dr. John C. Sibley, 23 March 1981. Faculty of Health Sciences Fonds, Rehabilitation Science, Administration, Box 1. McMaster University, Hamilton, ON.
[425] Westmorland, Interview; Polatajko, Interview.
[426] Westmorland, Interview; Polatajko, Interview.

College as an official program nor Mohawk graduates as occupational therapists, resulted in these individuals often having difficulty obtaining employment.[427]

Before the Regulated Health Professionals Act of 1991, CAOT was responsible for outlining the standards of qualifications to be an occupational therapist. CAOT standards held no official ramifications, as there were technically no legal minimum standards for occupational therapists. However, many employers required being a part of CAOT to be hired as an occupational therapist. There were some exceptions to this trend, typically in areas that had significant challenges hiring occupational therapists (e.g. northern Ontario). Nonetheless, CAOT refused to acknowledge Mohawk graduates as legitimate occupational therapists, beginning a decade-long argument between the Ontario government, Mohawk College, and CAOT.

The primary point of contention between CAOT, who had taken an official position against the Mohawk College occupational therapy program before its inaugural cohort began, and proponents of the college program was if occupational therapy could be offered at a college level.[428] Proponents of the Mohawk program highlighted the need for occupational therapists in Hamilton, the strength of the occupational therapy skills of Mohawk graduates, and the cost-effectiveness of a college program. CAOT, however, felt that earning a diploma was insufficient in creating a competent occupational therapist. Further, CAOT was concerned that lowering the educational level for entry to practice would be harmful for the profession. CAOT had recently decided to upgrade all education programs to an occupational therapy degree and allowing a college diploma path to entry to practice felt like a step backwards.[429]

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[427] MG28 I495, 1995 0002 17. Canadian Association of Occupational Therapy fonds, National Archives of Canada, Ottawa, Ontario.
[428] Letter to Steve Trujillo from Dr. John C. Sibley, 23 March 1981. Faculty of Health Sciences Fonds, Rehabilitation Science, Administration, Box 1. McMaster University, Hamilton, ON; Twohig ""Everyone Knows There is a Battle," 101.
[429] Twohig ""Everyone Knows There is a Battle," 101-102.

Interestingly, the professors in the Mohawk College program were occupational therapists themselves, registered with CAOT. As Muriel Westmorland (Evans), the director of the Mohawk program recalled,

> At the same time, this was really funny, at the same time I was also on the board of CAOT. But it was kind of like I was a different person at the board, it was so weird. I'd have people sort of talk to me about issues to do with OT in Canada and one time somebody even said: Are you the Muriel Evans that is running the Mohawk program? And I remember looking at this person and going have you decided then that you're not going to talk to me? I mean, it sounds bizarre, doesn't it? But it was pretty horrible at the time.[430]

Westmorland, a registered member on CAOT who was serving on the board, was also running a program actively disavowed by CAOT. She recalled how, coming from England, she had been unaware of the contention surrounding educational programs in Canada. She was employed by Hamilton Health Sciences and was excited by the opportunity to start a new occupational therapy program.[431]

Westmorland being on the board of CAOT as well as running the Mohawk program was not the only oddity. Tenley Kelly, a Mohawk program graduate, recalls how supportive the Hamilton community was of the college graduates, stating that "the Hamilton area was incredibly pro-Mohawk grads… a number of times I had therapists say to me, Mohawk students are better than any university students we get."[432] Helene Polatajko, in her formal review of the program, found similar results as Kelly's experience. Her assessment found that employers and clinical supervisors felt the quality of Mohawk graduates was high, and the only issue was that they could not register with CAOT.[433] Given CAOT's active investment in being able to generate

[430] Westmorland, Interview 12 July 2023.
[431] Westmorland, Interview 12 July 2023.
[432] Tenley Kelly, interviewed by Katie Lewis, zoom (Simcoe County and Hamilton), 11 August 2023.
[433] Helene Polatajko, Evolution of the Occupational Therapy Program at Mohawk College of Applied Art and Technology, March 1983, CAOT; Helene Polatajko, interviewed by Katie Lewis, Hamilton, 15 August 2023.

competent occupational therapists to fill occupational therapist roles, rather than being replaced by another profession, it seems curious CAOT would take such as strong stance against the Mohawk program.

After over 5 years of contentious planning, the Mohawk College program was determined to find success no matter the obstacles put forward by CAOT. After going in "blind" to the issues that would occur, Westmorland began the "very first problem-based OT program in the world."[434] Under Westmorland's leadership, Mohawk College taught students to use theoretical frameworks, which was a novel idea in occupational therapy education.

> In fact, we had a chance to have a group of students from Western come and visit. They were absolutely amazed to find out we were using a theoretical model… I went with a philosophical model of education and objectives with me and I was amazed to find that none of the universities had that. There was not a model, there was not a theoretical framework...[435]

Occupational therapy programs were struggling to justify being at a university level in part due to the lack of theoretical frameworks and research. Here was the college program, deemed insufficient by CAOT, and yet using the exact methods needed to justify university-level education.

Mohawk College found ways around CAOT's restrictions. Placement opportunities for students, for example, were sometimes difficult to find due to the contentious nature of the program. To combat this challenge, Westmorland and colleagues went to lengths to support students and find placement opportunities. Kelly recounted her experience hoping to go outside of Hamilton for a placement,

> When I came to my last clinical placement, I wanted to live in my hometown, which was Coburg, Ontario, and so I set out to get my own clinical placement. The OT from there was a very young, fairly new, grad, probably within about three years, she was from Queen's, so she was kind of reluctant but interested. So, one of the women from the

[434] Westmorland, Interview. McMaster University is presently known for its problem-based learning approach.
[435] Westmorland, Interview.

> program, the Mohawk program, went down with me and we hashed it out and she agreed to take me on, and I ended up working there for my first three years after. A lot of us kind of tried to do that to get wider acceptance.[436]

Professors at Mohawk met one-on-one with sites, went to areas in critical need of occupational therapists, and even went outside of Canada in pursuit of meeting their student's and program's needs.[437]

The Mohawk program, therefore, was keenly aware of the hostile arena in which it found itself located. Westmorland reflected on her approach to deal with the negative attitudes towards her students and program,

> The way I decided to fight all of this was to not go on the offensive, but to take the higher ground. So, I taught a course called the sociology of professionalism. I didn't want them [the students] too focused on being angry and saying, we're not being accepted. But to focus on what's the rubric of a profession. And often, I mean, you'll never believe this, but at some of the conferences I was blacklisted. I couldn't go to an education meeting. I dealt with a lot of prejudice. It was not a great time.[438]

Evidently, individuals within the Mohawk program felt significantly challenged in their experience and treatment from CAOT. After attempting to find a solution with CAOT and licensing for over a decade, Mohawk College, McMaster University and CAOT came to an agreement to move the program to McMaster University. Further, the option to obtain a degree completion was made available to Mohawk graduates, with permission to register with CAOT should they obtain the degree. Notably, the instructors and majority of the course content remained the same upon the program's move to McMaster, with additional courses added to fill a four-year baccalaureate degree.

This so-called "Mohawk College problem" nicely highlights the deep-rooted fears within CAOT that occupational therapy as a profession was at risk to transition into a technician type of

[436] Kelly, Interview.
[437] Westmorland, Interview.
[438] Westmorland, Interview.

role. Such a transition was occurring in the United States of America at the time, as well as in the United Kingdom. As "para" or "allied" health employees, many supervising bodies felt that occupational therapists could work as clearly labeled support staff in healthcare settings. CAOT and like organizations such as provincial societies for occupational therapy were highly invested in creating a professional identity that was one above a support staff type of role. In the case of Mohawk College, CAOT viewed a college diploma as a step in the direction of becoming a technician or a supportive/assistant level role. As Carswell stated, reflecting on her experience at CAOT during the introduction of the Mohawk Program,

> We [CAOT] were terrified because the government wanted to keep it a Community College. I sat on the Ontario government committee, and I don't know how often, I would come away thinking, oh God, please, this is just not going the way we want it to, that we needed it to go. I'm a diploma trained graduate, and many of us were, but we had worked really, really hard to be at a university level. That was really important. We felt, as a collective that the profession would continue to exist, otherwise, it would be subsumed in being an assistant, and that was something that we just didn't want. We felt that if Ontario would have gone the rest of Canada would have gone for the educational qualifications.[439]

For CAOT, allowing the Mohawk Program to exist ran the risk of later changing the level of education for all of Canada, and subsequently the professional status of occupational therapy. Unlike those within the Mohawk Program, who were focused on the quality of the graduates and the impact on their local context, CAOT brought national concerns into their fight against the program.

Interestingly, these goals in education again did not necessarily align with lived experience in practice. There are numerous recollections of occupational therapists being treated as less than physicians. This was not an uncommon theme amongst those who work in so-called allied health. Throughout the Rehabilitation Era and onwards, there have been distinct

[439] Carswell, Interview.

hierarchies in healthcare settings with physicians firmly located at the top. Even with a degree or diploma granted at a university, many occupational therapists were treated as assistants.

Jack of all Trades, Master of None? Challenges of Graduating Generalists

From occupational therapy's inception, there were few, if any, opportunities to specialize or focus within the field. Occupational therapy students received an overview of occupational therapy methods in a variety of different settings and populations, with the expectation students hone their skills on placements and in the workforce in areas of particular interest. Occupational therapy education programs therefore graduated and continue to graduate generalists, who learn and grow in different environments. One of the main consequences to graduating generalists in the context of an expanding scope of practice is that the nature of what constituted occupational therapy expertise often related to soft skills which would look different depending on the setting. For example, while an occupational therapist working in a mental health hospital and an occupational therapist working in a children's treatment centre would hold the same title and have participated in the same education system, the skills used, and their job descriptions would look drastically different. An occupational therapist working in a mental health hospital would run mental health groups, support individuals in finding and participating in meaningful activities, and draw upon psychology to support individuals returning to their lives. In pediatrics, occupational therapists would support children in developing their physical capacity to participate in activities, develop modifications to their environment and/or their task, and teach children how to participate in different activities of daily living with their condition.

As occupational therapists pushed into new practice areas, the challenge of highlighting a common and easily understandable area of expertise grew. Especially at the beginning of the Rehabilitation Era as well as in more remote settings, many new graduates had to create

occupational therapy departments in specific areas despite not yet being "experts" in much of anything. The decision to continue graduating generalists, even after expanding the entry to practice standard to be a four-year baccalaureate degree, therefore compounded and enabled the increasingly unclear scope of practice for occupational therapy.

Conclusion

Overall, the evolution of occupational therapy education was significant and varied over the course of the Rehabilitation Era. Starting the time period as a combined, single diploma level program, occupational therapy, led by CAOT, evolved to become a baccalaureate degree offered at universities across Canada. The challenges surrounding occupational therapy education speak strongly to the professional identity of occupational therapy as a field during this era. CAOT, representing occupational therapists, struggled against the federal and provincial governments, as well as post-secondary institutions, in their insistence that occupational therapy must be at the degree level. These sentiments were rarely endorsed by non-occupational therapists, and it took continuous enforcement of this standard from CAOT for other groups to accept.

Therefore, the fragile nature of occupational therapy's professional identity was made clear through external organizations, typically managerial bodies, arguing competent occupational therapists could be generated through a far lower standard of education than CAOT felt was reasonable. Educational standards thus began an arena where professional expertise was negotiated. However, this negotiation, ultimately won by CAOT, did not translate into practice. The case of Mohawk College makes this particularly clear, as local hospitals, politicians, and employers all felt a college level diploma could produce competent occupational therapists. This perception was on the heels of university education finally and consistently being separate from physical therapy and earning a degree.

Chapter 4: The Gender Challenge

From the outset, occupational therapy took its place alongside other caring professions such as social work and nursing as a suitable role for women. As opportunities in the profession increased after the Second World War, more women than men continued to see in occupational therapy a profession that aligned with gendered ideals of caring. As in other female-dominated fields, gender roles and gendered expectations placed constraints on the ability of occupational therapists to professionalize and create a professional identity. During the Rehabilitation Era, married women increasingly participated in the workforce, and middle-class women's organizations pressed for greater social, legal and workplace equality, but social expectations of their roles as wives and mothers continued. Many occupational therapists prioritized their family, in ways that shaped their attachment to the profession and their career decisions. They made different choices around working once their children were born, including by looking for part time opportunities. At the same time, the framing of occupational therapy as a female caring profession placed constraints on efforts to assert professional autonomy in the health care workplace.

Why Gender? Context of Women's Rights

Near the end of the Rehabilitation Era, in 1981, the Canadian government added Section 28 to its proposed Charter of Rights and Freedoms to state, "Notwithstanding anything in this Charter, the rights and freedoms referred to in it are guaranteed equally to male and female persons."[440] While such an interpretive clause could be seen as defensive – it sought to prevent judges from interpreting other charter rights in ways that might undermine gender equality – it represented an important legal victory in the decades-long struggle to establish the political, legal

[440] 1981 Charter of Rights and Freedoms.

and workplace rights of women. The Rehabilitation Era, arguably, directly overlaps with the period of greatest legal change for women in Canada.[441] While occupational therapy as a profession was expanding significantly into new settings and the educational system was generating more occupational therapists, women too were gaining more rights and increasingly participating in the workplace.[442] As a female-dominated profession, the rights of women generally interplayed with the development of professional trajectories for occupational therapists across Canada. The development of occupational therapy and its history must therefore consider the broader context of the notable changes in women's rights over the same time period to adequately understand the driving and constraining forces of Canadian women in professional settings.

Since its inception, women have made up the significant majority of the profession of occupational therapy. To this day, over 90% of occupational therapists in Canada identify as female.[443] Occupational therapy is far from unique with this demographic makeup, with other healthcare professions such as nursing, physiotherapy, speech and language pathology, social work, and midwifery also predominantly composed of women.[444] When considering the broader development of women working in healthcare, most historical work has focused on the role of gender in nursing.[445] This is due, in large part, to nursing being the most prominent healthcare

[441] 1981 Charter of Rights and Freedoms.
[442] Mary Kinnear, *In Subordination: Professional Women, 1870-1970*. McGill-Queen's Press-MQUP, 1995, 3-29.
[443] Canadian Institute for Health Information. "Occupational Therapists." Data tables, October 14, 2024. Statista. Accessed September 22, 2025. https://www.cihi.ca/en/occupational-therapists#:~:text=11%2C718%20occupational%20therapists%20(OTs)%20were,supply%20was%20younger%20than%2040. As of 2023 90% of occupational therapists identify as female.
[444] Canadian Institute for Health Information. "Occupational Therapists." Data tables, October 14, 2024. Statista. Accessed September 22, 2025. https://www.cihi.ca/en/occupational-therapists#:~:text=11%2C718%20occupational%20therapists%20(OTs)%20were,supply%20was%20younger%20than%2040. The male percentage increased in physio in the post-P & OT years. In Canada, 91% of physios were women in 1975, dropped to 85% in 1991, and down to 70% in 2023.
[445] Prud'Homme, "What is a "health" professional?" 89-90.

profession deemed to be "women's work."[446] When women first began to enter the workforce in significant numbers, and for decades after, work that involved "caring" was typically more open to allowing women to join the field. The nurturing and caring components, in addition to a high prevalence of women, are seen in many allied health professions. In the case of occupational therapy, many within the profession chose a nurturing and caring role through the focus on self-care. In cases where an occupational therapists role emphasized self-care, such as in-patient roles teaching independence in toileting and dressing, the role appeared similar to nursing.[447] As histories of nursing completed using a gendered analysis demonstrate, in the context of healthcare, a "caring" profession can be both a constraining and an expanding factor for women looking to participate in the workforce.[448] Similarly, work that has considered the "feminisation of the health professions" has found that the main reasons for feminisation were:

> The introduction of equality legislation, changing societal values perhaps influenced by the feminist movement increasing opportunities in higher education for women; and the impact of labour shortages and job growth on opportunities for women to enter the health professions.[449]

These factors, while infrequently directly applied to occupational therapy in historical analysis, appear congruent with the experience for Canadian occupational therapists. Due to its demographic make-up and position in the healthcare system, Canadian occupational therapy has much in common with professions such as nursing and is therefore comparably impacted by gendered forces in their history. However, as Prud'Homme and Rossignol argue, "female-coded

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[446] Boschma, Yonge, and Mychajlunow, "Gender and Professional Identity," 244.
[447] Mary Anne McColl and Mary Law. "Interventions Affecting Self-care, Productivity, and Leisure Among Adults: A Scoping Review." *Occupational Therapy Journal of Research: Occupation, Participation and Health* 33, no. 2 (2013): 110-119. https://doi.org/10.3928/15394492-20130222-01. A large percentage of occupational therapists focus on self-care activities, which also falls within 'women's work' roles.
[448] McPherson, *Bedside Matters*; Boschma, Yonge, and Mychajlunow. "Gender and Professional Identity," 243-255; Scaia, "Becoming a Nurse, Vancouver and Calgary," 91-118.
[449] Tracey Adams, "Gender and Feminization in Health Care Professions." *Sociology Compass* 4, no. 7 (2010): 454-465. https://doi.org/10.1111/j.1751-9020.2010.00294.x

professions that achieved legal self-regulation" cannot be grouped with nursing histories after the 1960s.[450] It is important not to group these professions together due to the different goals within the healthcare system, as well as the pursuit of allied health professions such as occupational therapy to work outside of hospitals. Allied health professions that obtained self-regulation typically looked to go beyond or outside of medical authority. As Prud'Homme and Rossignol state, "Medicare created a new structure of opportunity that allowed other professions to expand, notably though the creation of new clinical practices and the growth of new patient bases."[451] Though each allied health profession had different levels of success in their pursuit of roles outside of the hospital system, it remains relevant to make comparisons to nursing history with caution.

In the first half of the twentieth century, allied health professionals, as well as women in the workplace, had similar professional objectives in terms of increased recognition and perceived value.[452] As is demonstrated in the collection of works *Challenging Professions: Historical and Contemporary Perspectives on Women's Work*, professional women have a long history of attempting to change professional structures to alleviate the variety of challenges women have faced in the workplace.[453] One such challenge for many professional women, especially those in healthcare, was the challenge of scaling up smaller-scale changes made on an individual level. In the collection of essays captured in *Challenging Professions*, numerous articles highlight the achievements of specific women, far surpassing the gendered constraints

[450] Prud'homme and Rossignol. "From Healthcare Policy to Professional Politics," 266.
[451] Prud'homme and Rossignol. "From Healthcare Policy to Professional Politics," 270.
[452] Fred Donini-Lenhoff, "Coming Together, Moving Apart: A History of the Term Allied Health in Education, Accreditation, and Practice." *Journal of Allied Health* 37, no. 1 (2008): 45-52. A note on the term "allied health"- one that many professions, including occupational therapy, have had issues with, but is relevant due to its frequent use during this time period.
[453] Elizabeth M. Smyth, 1999. *Challenging Professions: Historical and Contemporary Perspectives on Women's Work*. Toronto: University of Toronto Press.

that one would expect during their historical setting, that did not manage to translate into broader scale changes for their respective professions. Meaning, while individual women could transcend gendered lines in some cases, often their achievements were not reflected in changes to the profession as a whole.

Occupational therapy, as a small and relatively unknown profession, felt this challenge of scaling accomplishments upwards in the hierarchal structure of healthcare. One interviewee, commenting on this very issue, summarized succinctly the challenges she felt were present over the course of her career, stating,

> We [were] a very weak group of women who [were] not very politically and strategically well informed, despite there being some very bright and proactive women amongst us. But there [has not been] enough of us, and we're not [have not been] connected.[454]

With this analysis, she is commenting on her perception of the challenge of being a small, predominately female profession during the Rehabilitation Era specifically. While not calling women nor occupational therapists weak, she is instead discussing her experience of the intersection between the gender and small size of a relatively unknown profession attempting to navigate political change. While there are numerous cases of individual occupational therapists causing significant change in their immediate context, occupational therapists often had significant challenge navigating change at the federal level. The barriers to expanding beyond their entrenched history have been keenly felt by occupational therapists, as they endeavoured to define their own scope of practice and advocate for their presence in relevant settings.[455]

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[454] Townsend, Interview. As demonstrated by the square brackets, here Townsend is using present tense, but is referring to how she felt during her career in the Rehabilitation Era. She is not stating that current occupational therapists are a weak group of women (nor am I).; Maxwell & Maxwell, "Occupational Therapy: The Diffident Profession," 140. The Maxwell Report echoed this sentiment, stating, "OTs did not really know the strategies to use in the arena of power, the strategies to use to fight and compete for scarce resources and favourable decisions. This was a "diagnosis" OTs made themselves."

[455] Maxwell & Maxwell, "Occupational Therapy: The Diffident Profession," 138. This report comments on the need to change from "a state of 'diffidence' to a state of 'confidence'." The report is speaking to situations such as occupational therapists knowing that they should be in the community, but often aren't funded to do so, or

These challenges in continuing or expanding upon the progress of an individual within the profession relate to many factors including professional identity and overall healthcare funding, but also specifically to gender. As histories of nursing, such as Kathryn McPherson's *Bedside Matters: The Transformation of Canadian Nursing, 1900-1990,* demonstrate, gender played a significant role in limiting progress for women at work.[456] McPherson discusses how gendered views of "women's work" influenced hospital structures and health systems, and how the combination of gender and proletarianization increased the challenges experienced by female nurses in Canada. According to McPherson, gendered forces are modulated to varying degrees by other factors including the history of the role, professional status, and domain of expertise.

The duration of the profession's existence, for example, factors into the gendered understandings of the role. Due to nursing's long history, the blueprint of an original nurse and related expectations continued in many ways past when nurses themselves looked to emulate those ideals. A similar case can be made for occupational therapy; as the profession began under close supervision of male physicians, the expectations of the "girls in green" carried on through the subsequent decades of occupational therapy.[457] Domains of expertise also tied in closely with these gendered ideals, as the areas women could be responsible for often fell within socially acceptable "women's roles" that involved caring or domestic types of labour. These ideals enabled women to physically leave their home to participate in the workforce, and yet constrained the areas of employment to those that held similar gendered ideals.

supervising bodies feel that they could replace occupational therapists with different allied health professions, such as a nurse.

[456] McPherson. *Bedside Matters*.

[457] Cockburn, "Change, Expansion," 3-6. Often called the "girls in green" during the very early years of the professions history as all occupational therapists wore a green uniform. These uniforms were worn until the 1960s, depending on the area of practice.

Unlike in the case of nursing, occupational therapy also had to manage the challenge of other professions not understanding the role of an occupational therapist. While entrenched historical perceptions of occupational therapists remained in some areas, there was another subset of individuals who had limited understanding of the role of an occupational therapist. Often, these individuals were physicians and therefore in a supervisory role to the occupational therapist. As one occupational therapist reflected, while early in her career working at a general hospital, certain physicians had no idea what she brought to the table. She stated,

> Every time I took any patient to them for a discussion, I had to use this particular approach. It was interesting because they really didn't know what an occupational therapist did, so my technique was to take a piece of paper, preferably coloured paper, if I had it, and stick it on the front of the chart and write: 'do not open this until you read the OT report'. Well, that got their attention. Needless to say, and after a little while, I found that they were actually listening to what I had to say because I had lots of observations. I had concerns… We had a resident [physician], a social worker and a psychologist, and none of them had ever worked with an OT before, so they didn't know what I could bring to the table. I had to educate them around what occupational therapy's role was.[458]

This occupational therapist, who would ultimately leave the role she referenced above because she could not support herself on the wages she earned, highlights the unknown state of occupational therapy during the Rehabilitation Era. She further stated that she was sometimes mistaken for being a secretary while at work. Reflecting on one interaction she had, she recalled,

> The matron, the nurse head nurse of the hospital. I invited her to come to a meeting to talk about how we were going to plan for psychiatry, and I remember when she met me, she thought I was a secretary and she just assumed that, you know, I was young. 'Where's the head of the department?' She said. I said, 'you're looking at the person who's in that position now.' It was tricky because you know as a young woman, then it was seen as really rambunctious.[459]

Her experience speaks to the nuanced challenges for occupational therapists in healthcare systems. As a profession fairly small in size, with a long history of being run by physicians,

[458] Interview x02d
[459] Interview x02d

occupational therapists in the Rehabilitation Era navigated a lack of understanding regarding their role as well as gendered assumptions as to which role the individual held.[460] Throughout the Rehabilitation Era, in many settings, the role of the occupational therapist continued to be defined by non-occupational therapists, such as physicians, in large part to the historical ways of doing. However, these individuals did not consistently understand the scope of practice and often made assumptions about both the individual and the role of occupational therapy. Regularly, this led to dependency on the individuals involved to determine the role of the occupational therapist, the value, and the weight of their work with clients, among other factors. Meaning, the role and scope of occupational therapy was negotiated between occupational therapists, supervising physicians, and patients in each interaction between the three groups. These negotiations resulted in notably different roles for occupational therapists across settings, individuals, and time. In the case of Westmorland, the rambunctious occupational therapist using brightly coloured paper to assert her value, she eventually felt seen as an important member of the team. However, for those less "rambunctious" or working for individuals with limited interest in the role of an occupational therapist, the overall experience was quite different.[461]

The Challenges of Work-Family Balance

One key challenge for occupational therapists, as well as working women more broadly, was how to balance responsibilities and expectations of motherhood with professional goals. This balancing act is a theme clearly highlighted across oral history interviews as well as in the literature. Margaret Scaia's "Becoming a Nurse, Vancouver and Calgary: Women, Work,

[460] *Royal Commission on Health Services: 1964: Volume I*, tabled in the House of Commons on June 19, 1964.
[461] Interview x01e

Motherhood, 1958 to 1976" argues that nurses were able to balance work with more traditional female responsibilities, primarily domestic caregiving. She further states that,

> An education in nursing offered young women an affordable and socially sanctioned opportunity for advanced education and a lifelong career that was unusual for women in these decades.[462]

Scaia demonstrates that female nurses used both gender and class factors to drive change, considering the negotiation that nurses participated in between domestic roles, value of female employment, and the sheer necessity of healthcare workers during this time period. Considering the influence of liberal and labour feminists, as well as the second wave of the feminist movement more generally, nurses "challenged practices in the workplace that mirrored the general lack of support for married working- and middle-class women."[463] While focused exclusively on the history of women in nursing, these findings are applicable to the history of occupational therapy due to the similar composition of the two professions.

Scaia's article and other related histories are focused on the intersection of gender with paid employment, and the tensions between the two. During the time period under consideration, the male breadwinner ideology was strongly present in Canada and limited many paid employment opportunities for women. Despite the clearly gendered overtones of caring and nurturing in nursing and related healthcare professions that allowed for increased presence of women in the workforce, these types of educational and employment opportunities simultaneously provided avenues for women to gain employment. Although there were notable professional benefits, Scaia also argues that nursing was challenging for mothers attempting to balance work and domestic roles, and that nurses as a profession were underpaid due, "in part, to systemic gender discrimination, to nursing traditions that emphasized altruism and service, and

[462] Scaia, "Becoming a Nurse, Vancouver and Calgary," 92.
[463] Scaia, "Becoming a Nurse, Vancouver and Calgary," 92-98.

to the assumption that a women's place was in the home…"[464] For nursing, paid employment was often considered socially acceptable, in large part due to the similar nurturing and caring roles that women typically filled in the home. Despite this general social acceptance of nursing being an appropriate role for women, there continued to be ongoing challenges for married women with children to continue working. Nurses looked to leverage the social acceptance in the workplace to continue to work after having children.

Occupational therapy has many similarities to nursing in this regard. Occupational therapists often take on a nurturing type of role, and the gendered, racial, and economic composition of occupational therapists was highly similar to nursing, especially during the Rehabilitation Era. Further, occupational therapists initially used a significant number of crafts in their work, which was considered an area in which women could have expertise.[465] Crafts included activities such as sewing and basket weaving, which occupational therapists would teach to their patients as therapeutic activities.

Occupational therapy's relationship with crafts provides a nice example of the transition Prud'Homme and Rossignol discuss with respect to female-coded, self-regulated professions. Occupational therapy courses contained instruction in craftwork throughout much of the Rehabilitation Era. However, occupational therapists themselves had varied degrees of appreciation for craft work. Some reported that they enjoyed crafting in school or became an occupational therapist specifically for crafting activities. Others did not enjoy crafting courses, to the degree that some students were put off occupational therapy entirely. Ultimately, however, crafts were infrequently used in practice due to their poor alignment with the medical model. In

[464] Scaia. "Becoming a Nurse, Vancouver and Calgary," 115.
[465] Beth Linker, "Strength and Science: Gender, Physiotherapy, and Medicine in Early-Twentieth-Century America." *Journal of Women's History* 17, no. 3 (2005): 124. Partially because these crafts could be done at bedside, partially because it fit within a Victorian identity, seeing "women as caregivers, healers by nature."

school, crafting courses incorporated medical model terminology, and eventually were abandoned altogether, only to be picked up as art therapy later in the twentieth century. The level of control occupational therapists had over crafts as a therapeutic medium, being taught in school but infrequently used in practice, highlights the changing nature of the role and level of control occupational therapists held over their own role. Crafting was often the key differentiating aspect of the education program between occupational therapists and physiotherapists, yet they were infrequently able to be used in their practice settings.

Navigating the level of control over their profession was not the only challenge for occupational therapists. As histories of female-dominated professions demonstrate, navigating having children as an employed woman was a common challenge. While society became more tolerant of women participating in the workforce, there remained many social expectations of women being a wife and mother above all else.[466] Occupational therapists were not always an exception to this rule. As one interviewee reflected,

> The whole idea of well, you know, you're going to be a mom. I have to say, [at] U of T, if you weren't engaged by your third year of your program, then there was something very wrong. We used to lose three quarters of the class to matrimony.[467]

She referenced the social expectation in the 1960s, highlighting that there was no point for women to gain career training once they were married. However, this was certainly not the desire for many occupational therapists. She herself did not follow such a path, stating, "That didn't happen to me. I worked consistently, even when I had kids."[468] Speaking over fifty years later, her decision to continue to work after having children was evidently a significant decision.

[466] Tolerant before they married and had children, after that there remained many social expectations of being at home with the kids.
[467] Interview x01j
[468] Interview x01j

In occupational therapy and other professions, women responded to these social expectations in a variety of ways. Some women, such as the above interviewee who promptly returned to work, used their newfound acceptance in employment to further their careers, remaining at work even if they had spouses or children. Others maintained the status quo, for various reasons, opting to stay home with their children and either end or take a multi-year leave from their profession.

When discussing their experiences with having children and considering how and if they wanted to balance their career with motherhood, occupational therapists had significantly different reactions and approaches. Some occupational therapists took little time away from work before returning in some capacity. These women typically returned to work promptly due to either desire or because it was a financial necessity for their family. One occupational therapist, who worked as both an occupational therapist and physiotherapist before moving into a teaching role at McMaster for the remainder of her career, reflected on her experience having children, stating,

> My daughter was born in ’74, and my son was born a year later in ‘75. When my daughter was born, I was bored. Every time she slept, I used to, you know, get antsy about going back to work and not that I wasn't a doting mother, but I got bored and antsy… I'm just one of those people that I just needed to go back. So, it wasn't long… it was wonderful for, for them and me. And so that's when I went back to work.[469]

She felt that returning to work was best for her from many perspectives and reported how much her children enjoyed daycare and spending time with their grandparents. She commented on how fortunate she was to have her parents as well as her in-laws living nearby, who were more than willing to support with childcare. As maternity leave was first guaranteed by the Ontario government guarantees in 1970 in the *Act to Prevent Discrimination in Employment Because of*

[469] Interview x01p

Sex or Marital Status 1970, the interviewee had children in the early years of being legally able to return to work after having a child, demonstrating the immense value of legal changes over this period.[470] The addition of maternity leave to the Labour Code also highlights the notable change occurring for employed mothers over the course of the Rehabilitation Era, namely being legally able to return to one's previous employment after having a child, which evolved along with social change.

She was not alone in her desire to remain working. Another interviewee reflected on her post-partum experience with her second child, stating,

> We were transferred, my husband was working for an oil company, he was transferred to Oshawa. So, with the baby who was, I think a week old, we moved from Montreal to Oshawa and for the first six months, I didn't work, and then my husband came home one day and said, you know, you better get a job because you're absolutely not a happy person sitting at home looking after two children.[471]

The above occupational therapists recognized, and had partners who recognized, that they were happiest working in their careers as occupational therapists. Over the course of their respective careers, both women became occupational therapy professors and held various leadership roles within occupational therapy organizations.[472] Even decades after their respective decisions to return to work promptly after the birth of their second child, each commented on their interest in motherhood and their choices being guided, at least in part, by what was best for their children. Evidently, despite a strong personal pull to return to work for the sake of their mental well-being, there were notable social expectations and logistical barriers that made such a choice difficult. Those who returned out of financial interest told similar stories about how it was simply for the

[470] This Act was also known as the Women's Equal Employment Opportunity Act. Paid maternity leave was built into the 1971 amendments to the Unemployment Insurance Act.
[471] Interview x01o
[472] Interview x01o; Interview x01p.

best that they return to work.[473] These recollections align with the ones above, plainly stating that holding employment was what was best for them and their family at that time.

As the above interviewee's recollection in particular alludes to, particularly her comments on being a doting mother, many women held conflicting desires between the expectations of motherhood and the desire to work as an occupational therapist. Other interviewees took years off to raise their children, sometimes returning to occupational therapy and sometimes not.[474] Judy Friedland, in her memoir, discusses her decision to prioritize her family and children in the early years of her marriage. Friedland commented that after she had her first child her "life now revolved around the new baby and the new home."[475] Friedland detailed the other ways she filled her time while her children were young- being the Dean's wife, a member of the Home and School Associations, and a doting mother, among other activities.[476] Channeling her occupational therapy training, Friedland found meaningful activities throughout her years away from the profession itself, and recalled how it did not cross her mind to remain employed as an occupational therapist after she had children. It was not for many years, and three children later, that Friedland would return to work in an occupational therapy role. Despite her extended leave, occupational therapy knowledge had come up many times in her life, and upon return to work she would ultimately become deeply engrained in the profession.[477]

Friedland's memoir captures the experience of many professional and educated women. Other interviewees echoed her experience of upgrading their diplomas and degrees at nighttime during their time away from actively working in occupational therapy, managing both their

[473] Interview x01x; Oral history thematic analysis, 2023.
[474] Interview x01r; Interview x02e; Interview x01e.
[475] Judith Friedland, *There Was a Time for Everything: A Memoir*. University of Toronto Press, 2022, 79.
[476] Friedland, *There Was a Time*. Her husband Marty was the Dean of the University of Toronto's law school.
[477] Friedland, *There Was a Time.*

homes and university courses. Around half of the interviewees also spoke of how they channeled their occupational therapy training and education into their children's school associations and other such volunteer positions, among a variety of additional endeavors to challenge themselves and contribute to their local communities.[478] Many of these occupational therapists ultimately returned to work, holding flexible, part-time positions to enable them to continue supporting their families in childcare and related roles. However, for most individuals, the early years of their marriage as well as while their children were in school, family life came first. If they held employed positions, their role as an occupational therapist was deliberately and effectively managed around the priority of their family. For many occupational therapists, including those who would ultimately hold high-level positions within academia, their career choices were predominantly influenced by their children, as well as their husbands' employment choices.[479]

Here, it is relevant to note that this is not an indictment of mothers who chose to prioritize their family over their careers, in whichever way that worked for their life. Not one interviewee shared any regret about their life choices as it related to their family, and a part of the developments made for women generally over the Rehabilitation Era was the ability to choose their own life path, be it employed or otherwise. However, it is important to consider the tensions of family life with one's career. Many occupational therapists chose to heavily prioritize their family, specifically at the expense of their career. This had cascading impacts on the profession as a whole, as one does not see such a trend in male-dominated fields. Having to choose between

[478] The period where women went to post-secondary yet still were socially expected to stay home is reflected in the incredible power/ efficacy of parent associations in schools at that time, among other areas. As Judy demonstrated, many educated women channelled their education into roles related to their children's lives.
[479] The use of the word "husband" rather than "partner" is reflective of the status of most interviewees. Broadly, there was not a significant number of openly queer occupational therapists in high level positions (e.g. at a university or at CAOT). At broader levels across Canada, there was not much in terms of representation until the 1990s and early 2000s. This language is not used to take away from the reality of queer occupational therapists who were in practice during the Rehabilitation Era.

family life and career, in the larger context of changing social norms, influenced the overall development of occupational therapy by influencing the demographics of leaders in the profession, the amount of time the average occupational therapist could commit to the role and related advocacy work, and the expectations others had for occupational therapists.[480]

On the other side of this coin is the specific set of circumstances that facilitated individuals to become leaders in occupational therapy. Thelma Cardwell and Isobel Robinson, two prominent figures for occupational therapy in Canada, never married and instead "complimented and supported one another, and gave themselves to the University of Toronto and to the profession."[481] Another leader in occupational therapy reflected that, "you could say that I advanced in occupational therapy mainly by being divorced and thus not encumbered by a husband."[482] Many leaders in occupational therapy were unmarried, with a smaller subset having husbands that supported their academic career. While these women often made significant contributions to the profession as a whole, their experiences were less frequently akin to the typical profile of an occupational therapist.

Near the end of the Rehabilitation Era, occupational therapists began to move in greater numbers into self-employment areas, which created a third route in navigating work-family balance. Reflecting on her role in founding COTA, Karen Goldenberg also specifically spoke to the optics of being employed as a wife. She reflected that, "… in those days, if a woman had to work, she worked, but if not, it was kind of...right? Your wife worked; it was disgusting."[483] Here she is speaking to the social shift in society on the position of wives (and mothers) working. She is highlighting that there was acceptance for women to be working if that was needed for

[480] Maxwell & Maxwell, "Occupational therapy: The Diffident Profession."
[481] Judith Friedland, "In Memoriam: Dr. Thelma Cardwell: 1920-2001" *OT Now* 3 (2001): 3-4.
[482] Personal communication with Elizabeth Townsend.
[483] Goldenberg, interview.

their family, but the idea of a wife working for any other reason than financial necessity was strongly looked down upon. Similar to Dagg and Friedland, along with interviewees who did not name these challenges as explicitly, Goldenberg outlines how significant societal expectations of wives and mothers influenced women's careers in occupational therapy. One solution she put forward, with a small group of other women, was creating an organization centered around flexible, part-time employment.

As Goldenberg described the rationale for the creation of COTA critically included possibilities for women to be self-employed. Goldenberg further stated,

> That was the premise, and the other was you need flexible part-time work for women because in that time frame… for many, work was full-time in hospitals and inflexible most of the time etcetera, etcetera. So many, many OTs and Physios, I imagine, but OTs, they didn't work, until we introduced this part-time flexible model. Hundreds of occupational therapists came out of the woodwork. Brilliant, brilliant women.[484]

Friedland was one of those women, who began working with COTA as an entry point back into the workforce while she still had children at home. Friedland's experience of scheduling clients around her family needs and maintaining a small caseload to facilitate this scheduling, was the experience for many occupational therapists employed by COTA. In fact, it was not for many years that COTA would hire their first, full-time occupational therapists. Goldenberg stated,

> I remember there was one woman named Kathy Lees… she came and said I have to work here; I just can't bear working in a hospital anymore. And I said, I can't guarantee you that I'll have enough work for you, Kathy, so I'm going to take a chance, and I'll figure out how to do that. And she became our first full-time committed, still a self-employed, person.[485]

Although successful enough at that point to sustain a full-time employee, the majority of COTA's "employees" were in fact independent contractors. As independent contractors, women

[484] Goldenberg, Interview.
[485] Goldenberg, Interview.

filled an entrepreneurial role, with total control over their hours and schedule. These women predominantly chose to work part-time, and were often mothers looking to hold a job that would challenge them while also facilitating their continued presence for all of their children's needs.[486]

COTA, therefore, exemplifies the experience for many occupational therapists who were wives, mothers, and wanted to remain occupational therapists as well. Although not always belonging to social classes that would approve of employed wives, occupational therapists sought creative ways to participate in part-time employment throughout their children's childhood. Unlike other professions such as nursing, who sought to use their gender as a method to continue participating in the workforce in a comparable way to before having children, occupational therapists who were also mothers instead leveraged their occupational therapy knowledge of environmental considerations to create a new organization that fit well with the needs of their lives.

The approach by COTA, as well as the experience of those who took time away from their role yet continued to apply their occupational therapy knowledge, demonstrates the difference for how gender intersected with the profession of occupational therapy, as compared to similar fields such as nursing. The flexible and evolving domain of expertise, as well as an education rooted in creativity, allowed for novel approaches within occupational therapy. Occupational therapists, while often facilitating their career around the needs of their family members, managed to continue to participate and expand the profession. This expansion, however, was typically inconsistent and person-dependant, due to the frequent prioritization of non-career activities. This type of expansion led to increased diversity of practice across occupational therapy settings.

[486] Goldenberg, Interview.

A Gendered Career

One of the largest themes spanning the oral history interviews was professional trajectories driven by the employment of their husbands. The women interviewed often referenced moves driven by their husbands' employment or educational opportunities, which were frequently at odds with their own career paths. Each interviewee was asked: "Did being female ever play a role in your career? In what way?"[487] in an attempt to highlight the individuals' conscious or unconscious perceptions of the influence of gender on their careers. In many cases, however, women would answer the gender question with a short "no" while also discussing at length the career choices they had made based upon their husband's work goals.

One interviewee, who responded, "No, no, I guess we just accepted that women were the OTs or whatever. Yeah, there was no question of it," told the story of her husband and children and how they influenced her career. [488] A dual-trained graduate, she switched from her preferred occupational therapy to a physiotherapy role "because there was a position available when we moved because my husband was moved there."[489] After moving on from that role, she then discussed her employment, sharing that she was,

> More pulled to the job rather than wanting to be an OT or a PT. Just to keep active when you had kids, because at that point I had kids, I sort of weaved my job in and around having kids.[490]

Despite not feeling that being a women impacted her career in any way, she told a story of her career as it related to what was best for her family, and in locations determined by her husband's choices of employment. She, as with many other professional women of this time, made no

[487] With the exception of the one male participant, who was asked if being a male played into his professional trajectory.
[488] Interview x02h.
[489] Interview x02h.
[490] Interview x02h.

reference to consideration of her career needs or goals in discussions of moves with her husband. As Friedland elaborates on in her memoir, there was no question that her career would not influence decisions made for the couple in the earlier years of her marriage.

Judy Friedland discusses the decision-making process in navigating her career and being a wife as well as a mother in her memoir titled *There was a Time for Everything*.[491] Her recollection, unlike other interviewees, has the benefit of deep reflection and integration of such reflections into her writing. Throughout her work, Friedland makes clear that she is revisiting the story of her life through new eyes, reflecting on the decisions made in a notably different phase of life.[492] Friedland reflected on the early stages of her career, after getting married while she completed her P & OT Diploma, she decided to leave a job she loved at the Toronto Psychiatric Hospital (TPH) to go to Cambridge for her husband, stating,

> We certainly didn't consider the possibility of me staying back in Toronto: that would not have crossed our minds. Nor did I consider this disruption to my life as unfair. It was unfortunate and sad for me, but there was no question I would go with him.[493]

This move was incredibly difficult for Friedland as a new occupational therapist who was significantly enjoying her career and role at TPH. She reflected on this time as a period of depression in her life, although she did not recognize it as such at the time. Looking back on her experience, she commented,

> Being taken back to Cambridge and away from the work that I had found so fulfilling in Toronto made matters worse. Not working fed my sense of isolation and general sadness. Marty, on the other hand, was fully engaged in his doctoral thesis and involved in the life of a graduate student. We were in separate worlds. Mine was constrictive and inward looking, while his was expansive, filled with interesting new people, all within an exalted university atmosphere.[494]

[491] Friedland, *There Was a Time*.
[492] Friedland, *There Was a Time*.
[493] Friedland, *There Was a Time*, 75-76.
[494] Friedland, *There Was a Time*, 78.

Though she makes clear she feels no animosity at her husband, nor regret for the decisions they made as a couple during that time together, she also makes clear that in the moment she was not considering any factors related to her career specifically when choosing where to live. Through her reflection on the decision-making process, it is evident that her husband's career was of utmost importance to the family, as was in line with societal norms in the late 1960s.

Other interviewees specifically commented on the challenges of being in a predominately female field, although they did not tend to go into depth on these challenges. One respondent commented that,

> I was certainly aware of it in my, my undergrad years in the P & OT program. It was all female profs [in occupational therapy], and it was all male profs with one female [in physiotherapy]. All the rest were men, and mostly they were all from Britain, and they were all not, you know, sort of not respectful of OT period. They didn't respect the OT Faculty, they didn't respect the OT students, but once I got beyond that, it didn't seem to be such a gender issue for me.[495]

While she discussed the larger system of power, and the lack of respect towards female occupational therapists, she stopped short at commenting that gender factored much into her career. The rest of the instructors or faculty she referred to, outside of the occupational therapists and physiotherapists, were male physicians. This reflection highlights that on the one-on-one level, in the case of her university setting, the disrespect was palpable and therefore prompted reflection about gendered dynamics in that context. However, for the majority of her career, her one-on-one interactions with men in positions of power were respectful, and therefore not an issue. Hers, and related responses, highlight the tendency for individuals to focus on their own experience and not necessarily reflect on the larger systems in place. Through their focus on smaller-scale interactions, they did not reflect on how gender factored into social expectations placed upon them.

[495] Interview x01q

Another interviewee chronicled the numerous, significant hurdles that she encountered in the early years of her career specifically due to her husband's choice of employment. As with other interviewees, she stops short of tying her experience of gender in her career with these challenging moves, instead simply mentioning them in the story of her career. For example, she commented,

> We came back [to Ontario, for a visit] in February knowing we were going to move [to Ontario] in June. We came back to find a house, and for me to find a job because my husband had a job. So, I went knocking on different doors. This was me cold calling everywhere.[496]

She told this story after chronicling her move out of Ontario to begin with, which had been also quite challenging for her education and occupational therapy career. She reflected on her educational experience, stating,

> …in my final year [third year], they changed the program so you could go straight through for the first time and get a four-year degree. But I had been married already for two years in university, I married at age 19 after first year of university, and my husband had actually taken a master's degree while I was doing my third year of OT school, and he was done. He was ready to take flight. So, we decided that I would be happy enough right now with my Diploma and we moved.[497]

Of particular relevance is the phrasing of *we* decided that *I* would be happy enough. Over the next decade, she ended up upgrading her Diploma as well as earning a master's and PhD, demonstrating that while she and her family were happy with her diploma in that moment, she wanted further education for herself. Ultimately, this earlier move worked out well for her career path, perhaps colouring her overall recollection of the experience.

Despite the notable influences of her husband on her career trajectory, her answer to the question of gender was focused on the difference in wages for male compared to female faculty in her academic positions. She reflected on her salary in academia, stating,

[496] Interview x01k.
[497] Interview x01k.

> Well, I just I wasn't even really perceiving the fact that we were earning less, the female faculty were earning less at the university. You'll read in Judy Friedland's book how they started to pay more attention to more equal pay for this for different genders at the University of Toronto. I vividly remember one day looking at my bank account and saying I have so much money in my bank account. The university had just infused a whole bunch of catch-up money, and then we got, you know, better wages. So that was one thing, being in a predominantly female [profession].[498]

Her reference to Friedland's memoir, and the change in pay for women more generally, is speaking to Ontario's Pay Equity Act, which passed in 1987.[499] Friedland chronicles her challenges for pay equity for years before and after this Act. Friedland, unlike many other interviewees, had the specific knowledge of male compensation and treatment, as her husband held various comparable positions at the same university as Friedland, the University of Toronto.[500] As mentioned, for others without husbands in academia, the pay gap was not always as glaring. Friedland attributes this to,

> a belief that, if a woman is married, and her husband is earning a good living (as in my situation), then she does not need to have a good salary for herself. This idea is not too far from the unstated idea that, if a husband is earning a good salary, there is no reason for a wife to work.[501]

Friedland, in turn, is referring to Anne Innis Dagg's experience of looking for employment in Canadian academic settings in the late 1960s and integrating that sentiment with her own lived experience.[502] Dagg, who at times took a similar approach of glossing over the influence of her husband's career upon her own within her memoir, shared her quite explicit experience as a

[498] Interview x01k.
[499] 1987 Ontario Pay Equity Act.
[500] Friedland, *There Was a Time for Everything.* Her husband (and later, son) actively encouraged her to fight for more money, knowing that she was doing a comparable amount of work that her husband had in a similar role, for a notably reduced salary.
[501] Friedland, *There Was a Time for Everything.* 158
[502] Friedland, *There Was a Time for Everything*; Anne Innis Dagg, *Smitten by giraffe: my life as a citizen scientist*. Vol. 22. McGill-Queen's Press-MQUP, 2016.

woman in academia.[503] She recalled, referring to her application to a vacant faculty position within the very area she had obtained her PhD, that,

> The dean of science, Bill Pearson, told us that he did not hire women, no matter how talented; their place was in the family, raising children. Besides, we all had husbands, mostly professors, so obviously we did not need the money.[504]

The social understanding that Dagg articulated so clearly is that even into the 1970s, there were a variety of factors that significantly decreased women's ability to participate in the workplace. Dagg's experience highlights a contrast in what occupational therapists were navigating, as Dagg reflected on her participation in a Faculty of Science; an area heavily dominated by men.[505] In contrast, occupational therapists were participating in a traditionally female-dominated career, within the social-acceptable caring role for women. However, as some occupational therapists looked to advance their career through employment teaching occupational therapy in university settings, a traditionally male area of employment, they began to run into this challenge.

The experience that Dagg, Friedland, and many interviewees speak to is reflected by the broader experience of women in academia, especially in the 1970s and 1980s. In her chapter within *The Illusion of Inclusion: Women in Post-Secondary Education*, Margaret Gillett articulates four phases before 2000 for women in Canadian academic settings. The 1970s falls into Phase III, where women made up nearly 50%, on average, of the undergraduate student population, but only 13% of the professor positions.[506] Further disparities occurred in areas such

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[503] Dagg, *Smitten by Giraffe*. 39 "As I was finishing my PhD in December 1966, my thesis supervisor alerted me to a part-time job teaching a one-term first-year course in zoology at the University of Guelph. I jumped at the opportunity. I would have enough time to prepare my notes, my neighbour offered to look after my children while I was away, and at the time I could reach the zoology building in Guelph in half an hour's drive. I loved teaching there during the spring semester and would have continued had it been possible, but we were preparing to leave in the summer for Ian's first sabbatical year, in Sydney, Australia."
[504] Dagg, *Smitten by Giraffe*, 42.
[505] Dagg, *Smitten by Giraffe*.
[506] Margaret Gillett, "The Four Phases of Academe: Women in the University." In *The Illusion of Inclusion. Women in Post-Secondary Education. Jacqueline Stalker and Susan Prentice (eds.)* (1998): 36-47.

as tenure track positions and leadership roles. Affirmative action initiatives in the late 1970s and early 1980s began to highlight the disparities for women in academic workplaces, however, it was not until after the Rehabilitation Era that significant change began to occur.[507] While patriarchal systems that led to a difficult work environment led many women to question or leave their academic roles, the tensions and challenges with family responsibilities was also a notable factor. Peta Tancred and Susan Hook Czarnocki in their chapter within *The Illusion of Inclusion* discuss the "revolving door" experience of many women in academia. Here, the revolving door refers both to the notion of not being able to achieve tenure status, stuck within a revolving door of similar opportunities without upward growth as well as choosing to exit academia despite strong qualifications. Tancred and Czarnocki discuss the synthesis of a challenging, patriarchal climate, and managing to keep up with the expectations of an academic role in combination with typical wife and mother responsibilities.[508]

Power Dynamics and Professional Boundaries

While gendered factors have begun to be considered by historians for allied healthcare after the 1950s, the field remains limited, especially in the Canadian context. Analyses that contrast allied healthcare professions that are dominated by women created before and after 1950, could provide relevant information on how deeply gendered understandings of roles remain with a profession. It appears that roles assigned to women as "women's work" in the early twentieth century created fairly deterministic paths that kept professions, such as occupational therapy, on a lower rung of healthcare hierarchies. The layer of gender interacts

[507]Anne Innis Dagg, "Hiring Women as at Canadian Universities: The Subversion of Equity." In *The Illusion of Inclusion. Women in Post-Secondary Education. Jacqueline Stalker and Susan Prentice (eds.)* Halifax, N.S: Fernwood, 1998: 108-118.
[508] Peta Tancred and Susan Hook Czarnocki, "The Revolving Door: Faculty Women Who Exit Academia" In *The Illusion of Inclusion. Women in Post-Secondary Education. Jacqueline Stalker and Susan Prentice (eds.)* Halifax, N.S: Fernwood, 1998: 119-132.

with the establishment of professional hierarchies, explored further in the following chapter, with occupational therapy's relationship, or typically subordination, to physicians.

One avenue that provides particular insight into the gendered and hierarchical dynamics of the healthcare system is the process of regulation. Many years prior to legal enforcement of professional regulation in Canada, there was a history of a "gentlemen's agreement" as a form of regulation in medicine.[509] The concept of regulation, even in the form of gentlemen's agreements, is heavily tied to the concept of professional identity and in turn professional autonomy. In the late 1800s and the early 1900s, the concept of a "professional" was essentially synonymous with "gentleman."[510] Further, individuals in society who were privileged enough to be accessing healthcare professionals insisted on those with inherently 'masculine' characteristics, such as those who were unemotional, physically robust, and committed to the job.[511] Occupational therapy began as a profession, in this context, where health professions were heavily dominated by men and male ideals. Occupational therapy's inception notably did not include any of the traditionally masculine traits highlighted as important for healthcare professionals. Rather, during World War I, occupational therapy "emerged as a discipline designed to nurture anxious patients through the use of gentle forms of manual labour, including beadwork and woodworking."[512] Using gentle modalities at the bedside set the profession on a distinctly feminine path, more akin to nursing. As Beth Linker highlights, in her work contrasting the fields of occupational and physical therapy, "the manual labor of occupational

[509] Anne Witz, *Professions and Patriarchy*. 1st edition. New York, NY: Routledge, 1992. https://doi.org/10.4324/9780203167786. 1-6.
[510] Nancarrow and Borthwick, The Allied Health Professions, 61.
[511] Nancarrow and Borthwick, The Allied Health Professions, 60.
[512] Nancarrow and Borthwick, The Allied Health Professions, 68-69.

therapy was not intended to be physically taxing."[513] As participating in occupational therapy did not make patients more rugged through trials of pain or physical challenge, and the occupational therapists themselves were gentle and nurturing, occupational therapy naturally fell far within the feminine domain, rather than having many masculine, professional traits. This initial, feminine, focus within occupational therapy had a distinct impact on the professional trajectory for the rest of the century.

In Celia Davies' chapter in *Regulating the Health Professions*, titled "Registering a Difference: Changes in the Regulation of Nursing" she argues that,

> Regulatory practices in nursing must be understood in terms of the triple historical subordination of nurses – as principally employed by the hospital authorities, as 'handmaidens' in relation to doctors, and as women in relation to men.[514]

While she is specifically speaking of nursing history, the commonalities of practicing at the bedside and using modalities with specifically feminine overtones, are highly similar to occupational therapy. Indeed, many have argued that the early years of occupational therapy were more similar to nursing than to physiotherapy specifically because of the approach used by physiotherapists.[515] Therefore, the above "triple historical subordination" rings true for occupational therapists as well, in particular the first and last factors mentioned.

In the early years of occupational therapy, due in large part to their scope of practice, the profession occupied a distinctly subjugated role under physicians. They maintained this subjugated position entering the significant expansion of public healthcare across Canada through the 1950s and 1960s. As access to healthcare drastically increased, physicians alone

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[513] Beth Linker, "The Business of Ethics: Gender, Medicine, and the Professional Codification of the American Physiotherapy Association, 1918–1935." *Journal of the History of Medicine and Allied Sciences* 60, no. 3 (2005): 320-354. https://doi.org/10.1093/jhmas/jri043

[514] Celia Davies, "Registering a Difference: Changes in the Regulation of Nursing," In *Regulating the Health Professions*. edited by Judith Alsop and Mike Saks, 94-95. SAGE Publications Ltd, 2002.

[515] Namely, that physios did not practice at the bedside, had physical expectations, and their work included pain/ suffering that one had to work through (all distinctly not female characteristics, despite being mostly female).

could not bear the entire load of health. However, physicians successfully advocated for control over the expanding number of allied health professionals. In this critical juncture of expanding healthcare and negotiations of professional scope, occupational therapists had to choose between continuing to work under medicine, or to refuse to submit to medicine and attempt to break out from their control. However, this choice was not entirely theirs to make, as occupational therapists were previously working interdependently with medicine and therefore were "compelled" to work under medical direction as the healthcare system changed.[516] Ultimately, due to existing structures stemming from feminine roots, to remain in existence occupational therapy felt a strong push to stay under medicine and their direction.

It is here where gender and a feminist lens is critical for understanding the decision to remain under medicine. While the size of the profession and history of subordination, both factors not unique to occupational therapy, factored heavily into the continued supervision by physicians, so too did feminine ideals. As physicians campaigned strongly and successfully to maintain power and influence within hospital systems, those smaller and previously subordinated professions needed to look towards private options to break out from under medicine.[517] The context of the 1950s and 1960s did not facilitate women running businesses- in reality it directly worked against this possibility.[518] Women were actively looking to be employed; the idea of working privately for themselves was not on the table for many years. COTA, one of the earliest successful examples of female occupational therapists working for themselves, did not begin until the 1970s.[519]

[516] Nancarrow and Borthwick, *The Allied Health Professions*, 84
[517] Nancarrow and Borthwick, *The Allied Health Professions*, 84-100.
[518] Kinnear, *In Subordination*, 3-29.
[519] Goldenberg, Interview.

Overall, as Tracey Adams and Ivy Lynn Bourgeault argue, gender inequalities underlie professional inequalities.[520] Occupational therapists, and comparable health professionals, make "uniquely female" contributions to the healthcare system.[521] Indeed, they were specifically allowed to participate in the workforce *due to* these feminine traits. However, this proved to be a double-edged sword, as "there exists a tension between ideals of feminism and ideals of professionalism, that has the potential to undermine female professional projects."[522] Meaning, these feminine ideals are often not congruent with the creation of professional boundaries and image, as these boundaries were specifically created in a patriarchal system.

Many occupational therapists reported gendered perceptions they felt occurred in various interactions throughout their career. Occupational therapists tended to most often report these interactions in academia and in leadership positions at CAOT or provincial associations. However, the concept of gender and their female status occurred across settings in interactions with male colleagues or superiors. Sue Baptiste, an occupational therapist who held many higher-level positions in academia as well as CAOT, reflected on her perceptions of the identity of occupational therapists. She stated,

> The OTs are the women who will say yes. They'll go get it. They'll go do that. They'll put the order in for you. They'll say yes to your menial task request… It's frustrating, it's tough because it's what makes everybody love us as well, so you don' want to vanquish that because OTs are consistently described as so lovely and kind, and so accommodating, right? They are great, perfect.[523]

While being tongue in cheek with her comment on "saying yes," her point remains of the agreeable image of occupational therapists. When polled in the Maxwell Report, nearly half of

[520] Tracey L. Adams and Ivy Lynn Bourgeault, "Feminism and Women's Health Professions in Ontario." *Women & Health* 38, no. 4 (2004): 73-90. https://doi.org/10.1300/J013v38n04_05
[521] Adams and Bourgeault, "Feminism and Women's," 73-90.
[522] Adams and Bourgeault, "Feminism and Women's," 73-90.
[523] Baptiste, Interview.

the occupational therapists respond that they spent more than twenty percent of their time doing tasks that could be delegated to an assistant.[524] The agreeable, near docile, image is tied strongly to feminine ideals often seen in the history of nursing as well. As Baptiste later highlights, occupational therapists themselves perpetuate this image through consistently being agreeable to the "menial" requests of others.

In this context, there is evident intersection of unclear professional boundaries with gendered expectations. As a predominantly female profession, occupational therapists were clearly in a support-level role, following medical orders for a patient or client. Compounding the gendered expectations, is the unclear role and scope of occupational therapy. Other professions, especially including those in supervisory roles, were often unclear of the professional boundaries around areas that fell within an occupational therapists' domain. As such, supervisors often requested a variety of different tasks for occupational therapists to complete that may or may not fall within the scope of practice. The sometimes "menial" nature of these asks can be understood through a gendered lens, with the expectations of women to be filling administrative and supportive roles. Occupational therapists themselves perpetuated this dynamic as well, as they did (and do) often say yes. Occupational therapists had challenges navigating the desire to be seen and participating on a healthcare team with agreeing to tasks that fell below their role. "Lovely, kind, and accommodating" descriptions are steeped in gendered expectations, while also being slightly different than words that would describe a nurse in a similar time.

The image of occupational therapists as those who will agree to any and all tasks requested of them ties back to the unknown professional image of occupational therapists. In settings where occupational therapy was better understood, often in paediatric settings,

[524] Maxwell & Maxwell, "Occupational Therapy: The Diffident Profession," 63.

occupational therapists did not highlight this challenge. One interviewee, who answered the question on gender with, "the short answer is no. It never really came up, no. I mean, I did work, I mean I would say 90% women through my career,"[525] told a somewhat conflicting story in her career history. In her summary of her employment during the Rehabilitation Era, the only supervisors she mentioned were men, who largely dictated her role. She felt respected and supported by her male supervisors, leading perhaps to her not commenting on the 10% of her colleagues that were men also tended to be colleagues that held roles above her own.

Unlike the above interviewee, the *Maxwell Report* found that occupational therapists had the most difficulty working with doctors.[526] While Maxwell & Maxwell found that overall job satisfaction was quite high amongst occupational therapists, their perceptions of other healthcare professionals as well as the public's value of occupational therapy role was quite low.[527] This difference is likely tied to the treatment occupational therapists felt from other healthcare professions, especially those in supervisory roles.

Overall, the expectation of an occupational therapist having a caring and agreeable nature tied strongly to the challenge in creation and maintenance of professional boundaries. Occupational therapists had challenges navigating the personality traits expected of them that enabled their participation in the workplace earlier in history with goals of defining boundaries of their scope of practice. Frequently, the success of this boundary negotiation was most influenced by the individuals involved, as occupational therapy continued to experience an external lack of understanding throughout the era.

[525] Interview x01g.
[526] Maxwell & Maxwell, "Occupational therapy: The Diffident Profession," 34.
[527] Maxwell & Maxwell, "Occupational therapy: The Diffident Profession," 32-33.

Sue Baptiste, reflecting on her experiences in leadership positions with CAOT, commented specifically on the precise challenge of working as the head of a profession entrenched in feminine ideals amongst male colleagues. She stated,

> But in all the aspects of my career, it's not been an easy thing to negotiate. When I was the President of the CAOT, for example, and I'd go for meetings with the, the heads of all the, all the associations we had nursing and physio and OT that were women, all the rest were men, even speech and language, recreation, et cetera. There are about five or six men and then the three of us [women]. And it was not always easy, because we were always seen as a traditional woman, right? We were always the women's professions, and I would get quite well, quite upset about that. So that was always it's always been a bit of a monkey on your back.[528]

Of particular relevance is her comment of being perceived as a "traditional woman." The role of an occupational therapist was, at its core, feminine, and therefore enabled Baptiste to be participating in the workforce. However, even though she was running the national association, she felt that she continued to be perceived as a traditional woman. Such a duality in her experience demonstrates the gender inequalities underpinning professional challenges. Femineity got occupational therapists one foot in the door but hindered their full access to professional autonomy and a clear professional identity.

Over the course of the Rehabilitation Era, the structural opportunities available to occupational therapists occurred on two levels. While there were increased employment opportunities and areas of practice for allied health professions, occupational therapy also navigated the structural opportunities available to women during this period. While occupational therapy was not alone in its predominately female composition, the intersection between gender and professional identity led to numerous hurdles in occupational therapy being able to realize the full spectrum of opportunities available with the transition to publicly funded hospitals. Occupational therapists navigated gendered challenges in different way than similar professions

[528] Baptiste, Interview.

such as nurses, due to their small size and their social understanding of professional expertise. The power dynamics present with gender in the workplace and gendered expectations of women's role within their family systems added additional challenges for occupational therapists to navigate while simultaneously attempting to improve the professional identity of the field.

Conclusion

The Rehabilitation Era ended in the mid-1980s, which marked the start of a shift toward prevention-focused medicine. Ottawa hosted the International Conference on Health Promotion in 1986, which was "primarily a response to growing expectations for a new public health movement around the world."[529] In focusing on proactive approaches, health promotion raised questions about the reactive and remedial nature of the medical model. As the focus across the health care system gradually began to move away from the medical model, priorities within occupational therapy were also shifting. Building upon the momentum started in the 1970s, the profession looked to expand outside of medicine and hospitals. The occupational therapy program originating at Dalhousie University, for example, began in the Faculty of Health Professions, with a curriculum developed with the concept of occupation at its core.[530] Further, with the development of *Guidelines for Client-Centred Practice* in the early 1980s (by CAOT, funded through the Department of National Health & Welfare), occupational therapy begun making tangible strides in articulating a scope of practice that did not include remedial, medical model thought processes.

[529] Lawrence W. Green and John M. Raeburn. "Health promotion. What is it? What will it become?." *Health Promotion International* 3, no. 2 (1988): 151-159. https://doi.org/10.1093/heapro/3.2.151

[530] Townsend, *Good Intentions OverRuled.* While this monograph looked at community mental health, there are many overlapping challenges. For example, Townsend looks at 'enabling participation' versus caregiving,' discussing the professionalization implications.

While occupational therapy began to move away from the medical model at the end of the Rehabilitation Era, decisions during this period left a mark on the profession. The significant growth within occupational therapy occurred within the context of the Rehabilitation Era, leaving much to change in the following years. The Rehabilitation Era was defined by a specific set of features that resulted in the notable impact on the profession. The expansion of the Canadian hospital system, led to different opportunities and occupational boundary conflict, while simultaneously increasing the prevalence of the medical model. As a profession with limited professional awareness and predominantly composed of women, occupational therapy had difficulty navigating the structural changes and opportunities that occurred during the Rehabilitation Era.

By examining the history of occupational therapy, this work makes both historical and occupational therapy contributions. Situated at the intersection of labour history, women's history, and medical history, the study of occupational therapy's history illuminates each of these fields and expands the general understanding. Occupational therapy history does not fit nicely into women's medical history, which is frequently focused on nursing or female physicians. As an allied health profession, much smaller in size than nursing, occupational therapy's history demonstrates the challenges of the intersection between a small and a gendered profession in healthcare systems. The experiences of occupational therapists navigating boundary negotiation of labour markets, in addition to their position as a small, female-dominated profession, provides more nuance to the understanding of these histories. Further, occupational therapy demonstrates the significant importance of looking beneath the umbrella of "allied health," in history and beyond, to understand the unique experiences of each of these professions.

For occupational therapists, this work helps to explain the challenges in finding agency, value, and identity in modern practice. In self-criticisms ranging from Muriel Driver in 1967 to Juliette Cooper in 2012, occupational therapists have identified concerns of focusing too heavily on introspection and not enough on external perceptions. These repeated calls to action have not yet been realized and demonstrated the need to understand the rationale behind such introspection. The study of medical history promotes humility in the present, through appreciation of the constant changes as healthcare evolves. By examining the larger context surrounding occupational therapy, this historical analysis of introspective and external perspectives, this work provides a grounding context towards making meaningful change in the future.

Umbrella of Occupational Therapy Professional Identity

The scope of practice of Canadian occupational therapy scope underwent significant changes, particularly throughout the course of the Rehabilitation Era. These changes are in part due to advances in medical science and increases in technology, as is expected in a healthcare field. However, many of these changes are also born out of the ongoing negotiation of occupational therapy's professional identity. Over the course of the Rehabilitation Era, the identity of Canadian occupational therapists was pushed and pulled in many directions, from within the profession itself as well as from many external entities. Ultimately, this changing and therefore inconsistent professional identity led to a fluid scope of practice, which in turn compounded the lack of clarity around occupational therapy's professional identity. Occupational therapy's scope of practice and professionalization pursuits mutually reinforced the challenge in achieving a concrete professional identity and scope of practice across settings.

The professional identity of occupational therapy is composed of four key levels, with each level laying the groundwork for the one above. Occupational therapy began developing its professional identity when the first education program started in the 1920s. Broadly, the educational system underpins the standards of practice, which in turn inform the areas of practice, and finally the scope of practice. Each level of the professional identity pyramid underpins the next, leading to the ultimate creation of the professional identity of occupational therapy.

Occupational therapy is different from other allied health professions as there has been limited consistency across Canada in each level of professional identity. Occupational therapy educational programs vary across schools and provinces, as there were no national standards created for occupational therapy education. During the Rehabilitation Era, CAOT began the accreditation process for occupational therapy schools.[531] Importantly, the accreditation process examined whether schools were indeed providing education on the areas they claimed to, rather than if each school taught unified core components of occupational therapy. Occupational therapy curriculum forms the base of occupational therapy identity as it strongly informs the *practice of occupational therapy itself*, through teaching students on the core tenets, philosophies, and approaches to be used in occupational therapy services.

Building upon these educational approaches to occupational therapy are the standards of practice. These standards are outlined on a provincial level and set the legal boundaries around practice. As with education, each province and territory have different legal boundaries around the role of occupational therapy. Most of the legal regulation around standards of practice began after the Rehabilitation Era concluded, however, the regional differences to practice within the

[531] "Annual Report of C.A.O.T Committee on Standards and Accreditation of Educational Programs," 1972, File B2017-0003/016 (07), Judith F. Friedland Fonds, University of Toronto, Toronto, Ontario.

Rehabilitation Era influenced the legal changes occurring in the years following. For example, in Quebec, occupational therapists do not need to write the national occupational therapy certification exam (NOTCE). Quebec was the only province to start regulation during the Rehabilitation Era, and implemented legal regulation before CAOT created the NOTCE.[532] These standards of practice "establish the minimum expectations for all occupational therapists" that work within the province or territory.[533] Standards of practice therefore form the next building block of occupational therapy's identity, at a provincial/ territorial level, by providing the lowest common denominator in terms of abilities and expectations. The standards of practice relate to the skills and capacity of occupational therapists, that can then be drawn upon in the workplace.

Areas of practice draw upon these legal standards. Areas of practice are settings negotiated between occupational therapists, managers, and other professions. Areas of practice are not specifically outlined in a legal framework, as long as they can fit within the standards of practice and are therefore socially and politically influenced. On this level of professional identity formation theories related to boundary negotiation factor in most evidently. Areas of practice are an iterative process that is highly dependent upon the immediate context, as occupational therapy must be in alignment with overarching goals of the practice setting.

Finally, there is scope of practice, which is the specific range of activities that occupational therapists perform. Scope of practice sits at the tip of the professional identity formation pyramid, as this consideration must fit within each lower level. Scope of practice is negotiated within area of practice, again adhering to the standards of practice. As scope falls within the three other levels of professional identity, in theory this should be the most specific

[532] Newell, "Occupational Therapy."
[533] Newell, "Occupational Therapy."

consideration. Due to its specificity, scope of practice often dictates professional identity, which illuminates why the public has notable difficulty in understanding occupational therapy's professional identity. Instead of being specific and narrow, the scope of practice in Canadian occupational therapy is broad and encompasses many different skills. Due to such a high variety of areas of practice as well as different standards and education across Canada, scope of practice also varies cross different settings.

Taken together, the four levels specific to Canadian occupational therapy's professional identity highlight the ever-increasing diversity of areas and scope of practice. Such significant diversity negatively influences the public's ability to understand the role, as it is very challenging to adequately capture the breadth of occupational therapy practice across settings. This diversity has its roots in the Rehabilitation Era, as occupational therapy expanded significantly during this period.

Education as a Building Block of Professional Identity

Educational programs played a significant role in the evolution of occupational therapy's professional identity. The development of education during the Rehabilitation Era was significant because of the rapid expansion, significant need for occupational therapy, and CAOT's decision to prioritize a university-level education as an entry to practice standard. However, because educational programs varied notably between schools, the use of education as a formative component of occupational therapy identity held mixed results. Educational programs varied by the combined or focused approach to occupational therapy, where the program was nested within the university structure, and how the expertise of the instructors guided the program's focus within the broad umbrella of graduating generalists. Those outside of occupational therapy understood the role on an individual or small group basis, depending on

their exposure to occupational therapy in their setting, but did not frequently appreciate the profession as a whole.

Part of the issue in increasing understanding on a broader scale was the differences between occupational therapists across settings. In her reflection titled "I Came to Canada" an occupational therapist from England named Archer reflects on her move to Canada in 1957. She observed that "Occupational Therapists are in short supply in Canada and there is no difficulty in getting a job."[534] Archer chose to work in the Rehabilitation Institute of Montreal, settling in a province home to many physiotherapists and occupational therapists that had also trained abroad.[535]

In Archer's experience working in the Rehabilitation Institute of Montreal, she found that her colleagues in both physiotherapy and occupational therapy tended to have significantly different techniques of doing rehabilitation. She states,

> Many Canadian therapists are dual trained, which means they have done a combined physiotherapy and occupational therapy course… Many of the older Canadian occupational therapists have had a single occupational therapy training in the same way as we do. Since coming over I have worked with English speaking Canadians, French – speaking Canadians, and Scotch occupational therapists, and we all got on remarkably well together; our general principles were much the same, although our techniques varied considerably.[536]

Archer's observations speak to the diversity of occupational therapists during this period. While there was an association for occupational therapists in Canada, there was not yet a consistent training expectation. The training programs in many countries were considered equivalent to

[534] P.W. Archer, "I Came to Canada." *Occupational Therapy: The Official Journal of the Association of Occupational Therapists* 20, no. 10 (1957): 29-30.
[535] Archer, "I Came," 29. Archer notes that all "physiotherapists and occupational therapists except two in Quebec are from England or Scotland… and there are very few French-Canadian therapists."
[536] Archer, "I Came," 30.

Canada's, and even within Canadian-trained occupational therapists there was diversity in education.

The diversity in education across Canada underpinned the diversity of practice. Joyce MacKinnon, who earned a Diploma in Occupational Therapy from McGill University in 1960, shared how she "set up the department in Charlottetown as a new grad."[537] The province of Prince Edward Island (PEI) had subsidised her education in occupational therapy under the condition that she worked in PEI after graduation for at least three years. MacKinnon was the only occupational therapist in Charlottetown, thus starting the department, treating "in and outpatients, adults, and children…", and ordering equipment, along with any other necessary occupational therapy duties.[538] Due to her lack of occupational therapy colleagues or experience, the education she received at McGill dictated the entirety of the occupational therapy programming in Charlottetown for years. Even after she moved, MacKinnon's organization left a lasting impact due to the start-up nature of her role.

MacKinnon was far from the only example of a new graduate from occupational therapy school starting an occupational therapy department, looking back to their education and requesting mentorship from former professors in their decision-making processes.[539] Later, these occupational therapy departments were influenced by hospital policies, the experience of new hires, and available funding. However, often many early influences from the creator of the occupational therapy department remained, given their formative impact. The practice of new occupational therapists starting departments was more common during the earlier years of the

[537] MacKinnon, Interview.
[538] MacKinnon, Interview.
[539] Barr, Interview.

Rehabilitation Era, as well as in more northern or otherwise remote areas. This occurrence highlights the foundational nature of occupational therapy education in professional identity.

Barbara O'Shea, in her Muriel Driver Memorial Lecture in 1977, spoke directly to the issue of occupational therapy education and its role in professional identity.[540] O'Shea discusses how "occupational therapists have tended to accept the professional image fashioned by others."[541] She attributes this decision to the experiences of occupational therapy students, specifically in practical placements. O'Shea argued that,

> Traditional practices which deflate professional self-image and perpetuate a subordinate relationship with physicians are currently being unconsciously transmitted to occupational therapy students.[542]

While the hospital structure was leading to unconscious learning, O'Shea further highlighted that students were not learning skills for professional interactions in school. Occupational therapy students were taught the specific tasks and interventions within occupational therapy, but "little real conception of the interactional behaviour appropriate for establishing or sustaining a professional relationship."[543] Essentially, in her lecture, O'Shea argued that occupational therapists are dependent on the patient or client validation of professionalism and expertise. Rather than entering into a negotiation of professionalism and expertise with clients, as would occur through Friedson's framework, occupational therapists were instead accepting the professional status, or lack thereof, outlined by managers and consumers. O'Shea attributes this to the educational experiences of occupational therapists, questioning if occupational therapy programs were graduating "pawns or protagonists."[544]

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[540] O'Shea, "Muriel Driver." Her lecture was aptly titled: "Pawn or Protagonist: Interactional Perspective of Professional Identity."
[541] O'Shea, "Muriel Driver," 101.
[542] O'Shea, "Muriel Driver," 106.
[543] O'Shea, "Muriel Driver," 106.
[544] O'Shea, "Muriel Driver," 101.

Though not explicitly using Friedson's theory, O'Shea's lecture highlights nicely the challenges occupational therapists had in negotiating professional expertise with both managers and consumers. In the context of physician increased control, O'Shea discusses how occupational therapists often accepted an image assigned to them. However, as physicians became more removed from the direct practice of occupational therapy, therapists continued to struggle defining their professional identity with consumers as well.

O'Shea appropriately attributes this challenge and lack of skill to the occupational therapy education programs.[545] Her analysis is congruent with the building blocks of occupational therapy's professional identity, with education and curriculum design serving as the foundational block. Occupational therapy students received a different education based on the institution they attended, but inconsistently had education on professionalism or professional identity. These students would go on to frequently work in isolation, attempting to negotiate professional expertise under the supervision of physicians and with clients who did not understand the role. Though not explicitly mentioned, her comments also relate to the gendered dynamics in healthcare settings. While O'Shea is attributing the "subordinate position" to confidence and professional identity, she is not naming the gendered layer that informed both of those factors in occupational therapy students. Occupational therapists were often subordinate to physicians as an allied health profession as well as subordinate to men as women. These compounding factors resulted in the challenges for occupational therapists and professional identity that O'Shea was seeking to address.

[545] O'Shea, "Muriel Driver"; Elizabeth Townsend comments during O'Shea interview. Writer attempted an oral history interview with Barb O'Shea, with support of Elizabeth Townsend. However, due to advanced memory deficits, the interview was not recorded. Townsend spent much of the interview reflecting and attempting to jog O'Shea's memory. Shortly after, in the early 1980s when Dalhousie University began its occupational therapy program under O'Shea's leadership, their curriculum held occupation at the centre of all courses in a pursuit of clarifying professional identity and expertise.

As occupational therapy curriculum did not focus upon professional identity creation during the Rehabilitation Era, the professional identity of occupational therapists became highly context dependent. Rather than emanating a professional identity that would then be negotiated between professions, supervisors, and consumers, occupational therapists were frequently reactive when they defined their professional identity. Meaning, occupational therapists would fill any missing roles in given contexts, conforming their role to the local needs. Such an approach led to a highly contextualized definition of professional identity, and one that would vary notably across settings and areas of practice.

CAOT, meanwhile, was actively looking to solidify leadership and improve the organization to strengthen occupational therapy's position as a profession. However, over the course of the Rehabilitation Era, CAOT did not make significant strides towards increasing the educational expectations of professionalism in schools across the country. In 1980, three years after O'Shea's call to action, Elizabeth Bell's Muriel Driver Memorial Lecture centred around role negotiation. Given that the Muriel Driver Memorial Lecture is selected by CAOT, the focus of these awards reflects their awareness of the issue of professional identity. In Bell's lecture, she states, "the fact that many other professionals hold inaccurate and often negative perceptions of our profession, may be the result of our lack of skill in role negotiation."[546] Bell includes a model of professional identity formation, in which "relevant O.T. education" and "identity" are directly tied.[547]

Healthcare Structure, Visibility, and Upward Mobility

[546] Elizabeth Bell, "Muriel Driver Memorial Lecture 1980 - Directions for the Decade." *Canadian Journal of Occupational Therapy* 47, no. 4 (1980): 147. https://doi.org/10.1177/000841748004700406
[547] Bell, "Muriel Driver."

Occupational therapy emerged as a role subjugated under physicians. This position in the healthcare system when entering the change to public healthcare in the 1950s and 1960s proved immensely consequential. During the period leading up to and during the transition to public healthcare, physicians successfully advocated to retain control over the expanding number of allied health professionals.[548] While the significant change in the Canadian healthcare system particularly highlighted the pursuit of physicians to increase their purview over the ever expanding roles within the umbrella of allied health, this was a general trend over the course of the century.[549] Over the course of the 20th century, the product of medicine and health was a dance for power between doctors and the state, where doctors desired more control and the state desired increased, yet cheaper, healthcare.

The position of, and approaches by, physicians then are necessary in understanding the creation of occupational therapy scope of practice and professional identity. Friedson argues that,

> 20th century professionalism in medicine became a means of advancing not just the immediate position of doctors in their own field, but extending their influence and authority over the ever more complex division of labour in health care.[550]

Therefore, although occupational therapy was already under physician control in the early 20th century, there was increased push to remain firmly under physician control with the transition into public healthcare and the expansion of the healthcare system more generally. According to Gerry Larkin in his chapter in *Regulating the Health Professions*, professionalism meant professional dominance for medicine (physicians), who employed key stratagems in promoting their dominance. Two of these stratagems, limitation and increased subordination, impacted

[548] Larkin, "The Regulation of the Professions," 121.
[549] Larkin, "The Regulation of the Professions," 121.
[550] Larkin, "The Regulation of the Professions," 121.

allied health professions most significantly.[551] While physicians were "extending their influence and authority," occupational therapy and similar allied health professions were having to navigate the challenges of this influence and authority.

The grouping of a variety of different professions under the umbrella of allied health facilitated increased control, and therefore subjugation, of these professionals.[552] Within Canada as well as internationally, such as in the United Kingdom, allied health professions were considered semi-professionals. Due to this semi-professional status, especially in stark contrast to physician colleagues, there was less urgency to stringently regulate allied health professionals. Indeed, in many provinces across Canada, occupational therapy was not legally regulated until after the culmination of the Rehabilitation Era.[553] The umbrella of the term "allied health" also reduces the strength of the individual profession through reducing the visibility of the role. Such a challenge was keenly felt by occupational therapists, who were already struggling with professional identity and lay understanding.

The grouping of various disciplines within a broad, and explicitly lower, status title resulted in limited opportunities for occupational therapists, as well as other allied healthcare fields, to develop professional autonomy. Using Abbott's and Freidson's theories together, the broader economic and social context did not provide for sufficient system disturbances. While these professions engaged in jurisdiction conflicts amongst themselves, there was not sufficient opportunity to break out from the broad category of allied health until the 1980s. Freidson locates the source of power within professionalism as being "exclusive jurisdiction and control

[551] Larkin, "The Regulation of the Professions," 121. There are 4 proposed by Willis 1983, the first two are 1) integration of rival occupations and 2) obstructing competitive claims from other practitioners to resources controlled by the dominant profession.
[552] Clouston and Whitcombe, "The Professionalisation of Occupational Therapy," 314–20. Patriarchal dominance played a significant role for most allied health professions before the 1980s. When the change happened, we see gender representation change as well, for the most part.
[553] Jecker and Newell, "Occupational Therapists," 261-278.

over work."[554] Occupational therapists did not have a high degree of exclusivity, as in healthcare that power was primarily reserved for physicians.

Another layer in the professional recognition of occupational therapists involved the supervision structure within hospitals. In the mid 1960s, hospital staff across Canada tended to be structured as professional departments. Meaning, there would be an occupational therapy department, run by an occupational therapist, who all occupational therapists across programs in the hospital would belong and report to. Having professional departments led to the opportunity for occupational therapists to move up the professional ladder, have a network of colleagues accessible, and have a visible group within the hospital. However, in the 1970s as well as into the 1980s, depending on the area within Canada, hospitals restructured to program-based supervision. In this restructuring, nurses were often program managers. This shift had two notable impacts on occupational therapy: there was reduced visibility within the hospital itself, and there were fewer occupational therapists in management positions.

Taken together, the influence of broader system structures and physician goals created a difficult environment for occupational therapy to thrive as a distinct, visible profession. Numerous concessions on areas of practice as well as the scope of practice felt critical for occupational therapy to continue as a member of the healthcare system. While these decisions took occupational therapy away from their early roots and into areas of practice that did not consistently feel comfortable, occupational therapists gradually adjusted their role to contain duties and approaches that felt congruent with their overall philosophy of practice and therefore professional identity.

[554] Jecker and Newell, "Occupational Therapists," 319.

The scope of practice is also distinct from the concept of a profession, which further problematizes the understanding of the professional status of the profession of occupational therapy. A profession "can be used to describe an occupation or group of occupations that share a number of normative traits which characteristically represent and define what it is to be a profession."[555] In part due to challenges of professionalization, the scope of occupational therapy is broad and the jobs of many different occupational therapists have little in common, despite holding the same title. A fundamental challenge throughout occupational therapy's history has been to develop a set of unifying principles that work in all areas of practice for all occupational therapists. Through the understanding that knowledge and power are social processes that determine a professional, the roots of the uncertainty surrounding the professionalization of occupational therapy are more apparent: occupational therapy is lacking the social understanding required of professional expertise.

While boundaries of professional scope are important in labour history generally, the context of healthcare adds a layer of nuance as the consumer and funder are typically different groups. As Friedson highlights, the boundaries of professional scope become a triangle negotiation, rather than simply between the profession and the consumer. This is particularly relevant in the Rehabilitation Era, as it begins with Canadian healthcare transitioning from a private to a publicly funded model.[556] This transition changed the managerial component, while also increasing the individual consumption of services. The increased access to healthcare services coincided with a social increase in the perceived capacity of medicine as scientific knowledge, preventative measures, and technology improvements. Together, these changes

[555] Clouston and Whitcombe, "The Professionalisation of Occupational Therapy," 314–20.
[556] Freidson, *Professionalism, the Third Logic.* Thus, significantly accenting the triangle formation of negotiation, rather than private which was closer to a direct negotiation between two parties.

mutually reinforced the increased production of healthcare professionals and expansion of their scopes of practice. A greater variety of healthcare professionals with increased capacity were more able to meet the growing demand of Canadian healthcare. Such an expansion significantly impacted the professionalization process for occupational therapy, as it occurred at a time where occupational therapy was actively looking to develop independence. Due to their significant advocacy and status within the healthcare system, physicians held notable influence over funding decisions, especially on smaller scales. For example, occupational therapy was not funded in hospital settings unless a physician provided a referral for the service. Through a referral stipulation in funding, physicians exerted significant influence over occupational therapy's relationship with funding bodies.

When considering the relationship between consumers of occupational therapy and occupational therapists, there was little engagement in the early part of the Rehabilitation Era. CAOT or another occupational therapy group did not appear to make a significant effort in marketing to high school students in hopes of attracting future graduates. Participants in oral history interviews tended to fall into one of three categories when asked what factors had led to them pursuing an education in occupational therapy. They had either planned on being a physiotherapist and had fallen in love with occupational therapy over the course of their combined program, had a relative who was an occupational therapist or a nurse and had told them about the role, or had stumbled upon a description of occupational therapy in a career description book a guidance counselor had provided and felt that it sounded appealing. There were also numerous instances of graduates of the combined course, who had planned on practicing as a physiotherapist, ending up taking an occupational therapy job as it was the only opening in a desired location. Consistent across these experiences are the accidental nature of

discovering occupational therapy. The experiences of interviewees in selecting occupational therapy as a career speaks to the general understanding of occupational therapy among Canadians. Individuals may be familiar through personal connections, but otherwise discovery of the field is largely left up to chance.

For most occupational therapists, underpinning career decisions are gendered constructs. Many occupational therapists left the workforce upon having a family or chose jobs specifically to facilitate their family life.[557] Many of the individuals who wanted to be a physiotherapist but chose to be an occupational therapist due to job availability did so because they relocated for their husband's job. Others chose to pursue specific part-time roles to facilitate being home as much as was needed. On the other hand, women who were "not encumbered by a husband" frequently filled leadership roles within the profession.[558] Be it through divorce or choosing not to marry, single women often led occupational therapy endeavours. Individuals such as Helen LeVesconte, who never married and influenced a high number of occupational therapists across Canada from her teaching at the University of Toronto, or Elizabeth Townsend who was divorced when she helped start the new occupational therapy program at Dalhousie University. Though these women were still subjected to gendered influences in the workplace, reduced expectations in the home helped progress their career and consequently the profession.

Ultimately, the common theme spanning the occupational therapist's lived experiences during their education was that the occupational therapy component had not been appealing. Some enjoyed mental health work and took to the role after a placement experience in that area. Others fell into the role due to job constraints and ended up enjoying it significantly more than anticipated. For many occupational therapists, it was not until they worked as an occupational

[557] Oral history thematic analysis, 2023.
[558] Townsend, personal communication.

therapist that they started to enjoy the profession and become interested in growing the role.[559] Physiotherapists, on the other hand, did market directly to high school students in hopes of recruiting future graduates.[560] Physiotherapists had the advantage of higher numbers, and therefore greater presence, in the healthcare system already, therefore increasing their visibility to consumers. In their shift into community settings through public funding, physiotherapists increased visibility even further with the public.

Thus, the public level of understanding of occupational therapy was (and remains in many ways) low. There are few examples of occupational therapy groups marketing towards the public, especially in the first half of the Rehabilitation Era. Individual interest and aptitude with business and marketing appears to be tied heavily to individual personalities, as is a theme with how occupational therapy is practiced more generally.[561] CAOT did have a publicity committee, but a large focus seemed to be publicity within hospitals and healthcare, not outward marketing to the Canadian public.[562]

Occupational Therapy Expertise and Scope of Practice

Throughout the Rehabilitation Era, occupational therapy education, the standards of practice, and the areas of practice were malleable and variable across settings. As time progressed and occupational therapists continued to find new areas of practice, the scope of occupational therapy also evolved significantly. With this fluctuation and expansion in areas of practice, occupational therapists were continuously negotiating their professional identity. A 2007 article by Hazel Mackey highlights confusion around the professional identity of

[559] Oral history thematic analysis, 2023.
[560] "Annual Report," 1970-80. MG28-I495, 1995/0002 4, CAOT Fonds, National Archives, Ottawa.
[561] Oral history thematic analysis, 2023. This is also the case with the professional background of the occupational therapist's husband (e.g. more examples when husbands are lawyers).
[562] "Annual Report," 1970-80. MG28-I495, 1995/0002 4, CAOT Fonds, National Archives, Ottawa.

occupational therapy. She discusses the conundrum that while occupational therapists are professionals, there seems to be no consistent definition of the role and, in turn, a broad scope of practice.[563] Mackey employs methods of dominant discourses and Foucault to analyze occupational therapy's professional identity.[564] She states that,

> the weakness of the collective professional identity of occupational therapists, alongside the performativity culture and workforce redesign, has presented occupational therapists with new opportunities to redefine their professional identities.[565]

Mackey's article highlights the highly negotiated nature of occupational therapy's scope of practice during this time. A scope of practice should be a clearly outlined set of skills that a profession holds professional expertise over or within. This approach to scope of practice is clearly demonstrated in similar health professions, including physiotherapy. Occupational therapy's weak collective identity, in combination with working in such a wide variety of different areas of practice, makes it incredibly challenging to coherently outline discrete activities that occupational therapists could complete and therefore assert expertise.

Here, the consequential nature of having an unclear scope of practice with increasingly diverse areas of practice is clear. Occupational therapists, feeling uncomfortable and not well understood in many settings, spread into different areas that felt more intrinsically aligned with their education and models of practice. In doing so, the occupational therapist may have felt personally more comfortable, but simultaneously increased diversity of practice and reduced the clarity of the broader occupational therapy. The educational system and entrenched areas of practice both influenced this discomfort with the locations of practice area of practice and

[563] Hazel Mackey, "'Do Not Ask Me to Remain the Same:' Foucault and the Professional Identities of Occupational Therapists," *Australian Occupational Therapy Journal* 54, no 2. (2007): 95–102. While publishing in an Australian journal, Hazel was from the United Kingdom and speaking about the United Kingdom, reflecting that the challenges of occupational therapy identity spanned internationally as well as within Canada.
[564] Mackey, "'Do Not Ask Me to Remain the Same,'" 95-102.
[565] Mackey, "'Do Not Ask Me to Remain the Same,'" 95.

subsequent lack of clarity surrounding occupational therapy's scope of practice. However, so too did occupational therapy's internal comfort with their professional identity.

In their monograph, *The Making of Rehabilitation: A Political Economy of Medical Specialization, 1890-1980,* Glenn Gritzer and Arnold Arluke examine the relationship between progression of technology and expansion of knowledge in relation to specialization. They argue that "rather than causing specialization, knowledge and technology can be resources used by interested groups to justify speciality status and dominance in a division of labor."[566] Gritzer and Arluke expand this understanding in the context of medical rehabilitation, rejecting the natural growth model to instead give more credence to the market model in explaining the division of labour in rehabilitation medicine.[567] Though this lens, it is clear to see the areas of challenge for occupational therapists. Occupational therapy had significant difficulty justifying specialty status and dominance in a division of labour, as they were ever shifting in their areas of practice and did not have a consistent knowledge base to reference. Further, as highlighted in the *Maxwell Report*, occupational therapists struggled immensely in any articulation of dominance over an area or skillset.

Many professions under the umbrella of allied health have "felt a 'sense of threat, attack, and hostility' in their struggle with one another over the preservation and expansion of their own occupational boundaries and professional autonomy."[568] Such a similar sentiment shared by different professionals suggests that the challenges of professional identity are not limited only to occupational therapists within healthcare. The consistent feeling of threat over their occupational boundaries also helps to explain the frequent changes to occupational therapy's scope of practice.

[566] Gritzer and Arluke. *The Making of Rehabilitation,* 7
[567] Gritzer and Arluke. *The Making of Rehabilitation*, 7.
[568] Gritzer and Arluke. *The Making of Rehabilitation,* 12

Occupational therapy has appeared to experience a greater level of challenge when it comes to professional identity, despite comparable allied health professions also reporting threats to professional autonomy. Friedland speaks to the cyclical nature of challenge in threats to professional identity leading to changes in scopes of practice, in turn leading to unclear identities, and subsequently threatening professional status.[569] Friedland demonstrates one aspect as to why occupational therapists had particularly difficult experiences with professional expertise and identity. Namely, Friedland posits that occupational therapy does not fit well within the field of rehabilitation. She argues that "although occupational therapy and rehabilitation are often considered synonymous, the latter is but one aspect of the former."[570] Friedland maintains that the philosophical roots and origins of occupational therapy "had little in common" with rehabilitation.[571] Furthermore, she argues that,

> … as occupational therapy became incorporated into rehabilitation, the profession's core values eroded, and although current definitions of rehabilitation offer a more appropriate fit for occupational therapy, rehabilitation continues to see engagement in occupations as a separate and subsequent step.[572]

Here, Friedland is demonstrating the cascading influence of discomfort with the medical model had on occupational therapy's scope of practice. When making the decision to align with the medical model, thereby compromising on core components of occupational therapy, the clarity of the scope of practice was significantly negatively impacted for the remainder of the Rehabilitation Era and beyond.

Bourgeault and Merritt, in their chapter titled "Deploying and Managing Health Human Resources" further comment on the socially negotiated, and historically entrenched, nature of a

[569] Friedland, "An Awkward Alliance," 373–80.
[570] Friedland, "An Awkward Alliance," 374.
[571] Friedland, "An Awkward Alliance," 374.
[572] Friedland, "An Awkward Alliance," 373.

profession's scope of practice. In their chapter, they highlight themes touched upon in several Muriel Driver lectures, as well as interview responses. They state,

> The preparation to take on those roles [scope of practice] through health professional education programmes and their consequent socialization into their profession while in these programmes add another layer of social dynamics to health professionals' scopes of practice. Thus, although the notion of a healthcare division of labour and the articulation between different health professional scopes of practice may be rooted historically in economic concerns, it also entails social and cultural dimensions.[573]

Occupational therapy demonstrates the complexity of this negotiation through its historically economic concerns that are deeply intertwined with gendered constructions, further compounded by the socialization between professions. Ultimately, these complex negotiations within professional circles consumed much of occupational therapists' time, both on association and individual levels, reducing the capacity to communicate with the consumer base.[574]

While occupational therapists met many aspects of the definition of a professional role, critically, a self-determination piece was missing throughout the Rehabilitation Era. Within the healthcare system, there was limited power available to occupational therapists, power that is a critical component of professionalism. Here, the notion of power and control demonstrates the tension that Freidson discusses between professionalism and managerialism.[575] According to Freidson, bureaucrats often demonstrate managerialism by claiming

> …to possess an advanced but general knowledge that is superior to the knowledge of both consumers and professionals due to their ability to organize work more rationally and efficiently.[576]

[573] Ellen Kuhlmann, *The Palgrave International Handbook of Healthcare Policy and Governance*. London: Palgrave Macmillan UK, 2015. 308
[574] Here, "consumer" refers to the consumers of healthcare.
[575] Kuhlmann, *The Palgrave International Handbook*, 300–302.
[576] Clouston and Whitcombe. "The Professionalisation of Occupational Therapy," 314–20; Freidson, *Professionalism, the Third Logic.*

In the context of the Rehabilitation Era, managerialism contained more power compared to professionalism, and therefore limited the professional capacity of allied healthcare members, as well as impacting how they were perceived by the general public. Occupational therapists struggled significantly with gaining or asserting power within the professional-managerial dynamic, experiencing significant professional challenges as a result. Gendered constructs as well as an unclear professional identity combined to create many barriers for occupational therapy to clearly assert power in the professional-manager context, thus shaping occupational therapy areas of work.

Occupational therapists were not the only profession supervised and constrained by physicians during this period. However, this history of physician control played a significant role in professional identity in the context of an evolving healthcare system. Professions responded in different ways to physician control and supervision, influenced by factors such as the gendered makeup of their workforce, their pre-existing relationships with physicians, consumer need and understanding, among other factors.

As their scope of practice evolved, and public understanding remained stagnant, many occupational therapists had trouble succinctly defining their own profession. While there are clear, historical roots in the challenge of defining the scope of practice, many occupational therapists looked at the name itself as a component of the unclear professional identity. When asked if they liked the title of occupational therapists, interviewees had varied responses. One commented that,

> It's confusing for the lay public, very confusing, always has been. They look at it as occupation, you know, somebody's working at something. It's confusing, for me, I understand it, I understand the grassroots, I understand the models. To me it makes sense, but, to the lay public, it's continually misunderstood… Everybody understands therapy, they don't understand occupation. Even our models are detailed, like occupational performance, person, environment. Then you break that down, and oh gosh, oh

> occupational performance components, you know, Katie, I just, do we really want to change it, or do we really want to help the public understand it better?[577]

As she continued to answer and ponder the question, the career-long struggle of defining the profession became evident. She went on to say,

> It needs to be really more visible it, I mean, I think I thought that years ago but if you're working in the practice area, if you had a significant event health disruption and you understand it, you understand the value of it, but other than that, it really needs to be promoted in a better way. And I don't know the answer to that, I honestly don't, other than individuals who are in the practice. **(Katie)** This is the eternal struggle. **(Adele)** It's totally the eternal struggle. And do we really want to change it? I don't know. [578]

Evidently, the challenge of the title of occupational therapy carried significant weight. Over the course of her answer, trying to capture what the essence of occupational therapy is and how one could easily communicate it to the public, she grappled significantly with a reasonable next step for the profession.

She was not alone in grappling with the title of occupational therapist. Another interviewee, when asked whether occupational therapy is the best name for the profession, responded,

> Not particularly. I don't know what would be better. I guess because people associate occupations with vocational kinds of situations, and although some of our work does deal with vocational goals for people, I don't know what else it could be called. When you think of what OTs in physical medicine are doing, making splints and lugging around raised toilet seats and things like that, when you think of activities of daily living I mean, maybe it could be called activity therapy, I don't know, but I think that's been a problem for our profession from day one. What is it called and what we do? I mean, a lot of what we collectively do is far removed from occupations, but some would say it shouldn't be. We should always be dealing with occupational and functional assessments and what people need to do to be more self-sufficient and independent and so on. But anyway, it is a bit of a problem.[579]

[577] Martin, Interview.
[578] Martin, Interview.
[579] Bluma Goldberg, Interview by Katie Lewis. August 17, 2023.

Similar to the previous interviewee, her answer took a meandering path as she tried to capture her work in a single word or title. She, as have many occupational therapists, oscillated between contemplating if the profession should work on centering occupation more clearly or come up with a new title entirely. Another interviewee, speaking to the concept of occupation itself commented,

> Occupational is a little bit, it distorts the work, but maybe it is your occupation when you're retired to live life to the fullest? I don't know, but I don't spend a lot of time worrying about semantics… It's life skills, isn't it? It's life skills, whether it applies to work, or home, or parenting, or aging. The determinants of health. It's helping people to function at their highest level, with dignity. That's what we do…I think occupational is wrong in the end…It's not occupation. Unless you use the term very broadly. The understanding is very work-based, which is not helping our marketing.[580]

Each of these interviewees comment on the challenge of the vocational ties of the term occupation, and how that challenge personally impacted their practice over the course of their careers. Such an experience is incredibly common for occupational therapists who do not work in vocationally related settings.

Others, who held roles that involved vocational components, felt fonder of the title. One commented,

> Occupational Therapy, yes, not OT. I've always said that because OT stands for overtime you don't want to perpetuate people's misunderstanding. It's occupational therapy. Although, when I went into the profession, when I went into school, you know, I had to have that explained to me, for sure that it wasn't just about work.[581]

Despite enjoying the title, she did still acknowledge the learning, or unlearning, process around the term "occupation." Ultimately, as the interviewees highlight, the title of occupational therapist brings conflicting feelings and a notable lack of clarity. The struggle occupational therapists feel with the title is an appropriate metaphor for the struggle of professional scope of

[580] Goldenberg, Interview.
[581] Rebeiro Gruhl, Interview. She commented this after I made the gaff of asking if OT was the best name rather than fully stating occupational therapy.

practice. Occupational therapists appear to have similar sentiments, and yet struggle to concretely define and express the exact nature of the unifying aspects of their profession.

In her article on occupational therapy's professional identity, Cooper makes the argument that as of 2007, occupational therapists have a consensus on the term "occupation."[582] Cooper cites the Polatajko's 2007 definition of occupation as "an activity or set of activities that is performed with some consistency and regularity, that brings structure, and is given value and meaning by individuals and a culture."[583] This definition, while common within the profession, is significantly different from a lay person's understanding of the term. A common understanding of the term occupation would include "a job or profession; the action, state, or period of occupying or being occupied by military force; the action or fact of living in or using a building or other place."[584] Due to this significant disconnect, Cooper argues "to maintain and advance its status as a profession, occupational therapy must ensure that its central tenet – occupation - is understood and valued by the general public."[585] While she is speaking decades after the culmination of the Rehabilitation Era, the nature of the lay understanding of occupation and occupational therapy was clearly not solved within the Rehabilitation Era.

Ann Wilcock echoed Cooper's sentiment, arguing that "meaningful occupation" has been occupational therapy's identity underpinning most of the profession's history.[586] Over the course of the Rehabilitation Era, the legislative and funding changes, in combination with occupational therapy's gendered identity, created prime systemic conditions for occupational therapy to advance from early understandings of "meaningful occupation" into the narrowing of a scope of

[582] Rebeiro Gruhl, Interview.
[583] Cooper, "Reflections on the Professionalization," 205. Cooper is citing Townsend, Elizabeth A., and Helene J. Polatajko. "Advancing an Occupational Therapy Vision for Health, Well-Being, and Justice Through Occupation." *Ottawa, ON: CAOT Publications ACE.* (2007). p. 19.
[584] Staff, Merriam-Webster. *Merriam-Webster's collegiate dictionary*. Vol. 2. Merriam-Webster, 2004.
[585] Cooper, "Reflections on the Professionalization," 207.
[586] Ann Wilcock and Clare Hocking. *An Occupational Perspective of Health*. Routledge, 2024.

practice. This narrowing occurred to facilitate occupational therapy finding their place within the healthcare system, as a profession composed of "women reluctant to stand out as leaders," who preferred collaborative relationships with clients over hierarchical expertise, and who had limited scientific evidence for their field.[587] The synthesis of these factors in the backdrop of a shifting healthcare system lent itself to occupational therapy choosing the stability and status of medicine while losing the potential of a broader, but less measurable, scope of practice.

Evolution and Contestation of Occupational Therapy Practice

As the Rehabilitation Era progressed, occupational therapists began taking up the mantel of defining their role, scope, and value to physicians as well as other team members.[588] The experience occurred time and time again, especially as occupational therapy departments were initiated. However, stereotyped perceptions of occupational therapy lived on for many others. While occupational therapists spent considerable time and energy explaining roles to colleagues and supervisors, much less time was allocated to explaining roles to patients or consumers of healthcare. While occupational therapists frequently made notable strides in improving understanding amongst their colleagues, these improvements tended to remain on the level of the individual. Meaning, improved understanding of occupational therapy did not often translate into greater understanding within the healthcare system, or amongst the public.

Such a challenge looking outwards, beyond the profession itself and towards navigating relationships with others was born out of occupational therapy's discomfort with the medical model. As the medical model was prevalent in healthcare at the time of the system disturbance of publicly funded healthcare, the medical model often informed the fabric of practice contexts for

[587] Maxwell & Maxwell, "Occupational therapy: The Diffident Profession."
[588] Oral history thematic analysis, 2023.

occupational therapists. Occupational therapists were generally uncomfortable with medical model methods, and the profession grew increasingly incongruent with the medical model as occupational therapy more explicitly considered an individuals' environment. To address this incongruency, occupational therapy looked to change their own profession first. This discomfort with practice settings facilitated an increasingly diverse array of practice settings as occupational therapists looked to work within areas that fit with their understanding of health and wellbeing. As occupational therapists increased the area of practice settings, their identity became more unclear, as the unifying components of the role across all practice settings required increasingly vague language to adequately include all areas of practice.

Compounding this challenge in identity, was the difficulty occupational therapists faced in meeting traditional definitions of expertise. Foundational to the concept of expertise is limits to one's expertise. Meaning, boundaries clearly defining the end points and concepts *outside* of a scope of practice are comparably important to defining the discreet skills *within* a scope of practice. As a small profession composed primarily of women, keen to demonstrate their value, occupational therapists often had a challenging time declining tasks. Given the spectrum of areas of practice, skills considered outside of an occupational therapist's scope of practice we not always clear. Further, these skills that occupational therapists would not use changed based on the location within Canada, the educational background of the occupational therapist, and the practice setting itself. As CAOT operated at the national level, it was challenging to adequately navigate the provincial differences in healthcare regulation. The small size of the profession required a national organization for adequate representation, thus worked against the attainment of a clear professional identity at the provincial levels.

The Rehabilitation Era served as an accelerant to occupational therapists' increasing challenge in defining what skills lay outside of their professional boundaries. The fragile professional identity entering a period of rapid growth led to a variety of new graduates starting occupational therapy departments. In this context, with physicians looking to leverage increasing control while having decreasing knowledge of the role of occupational therapy itself, they frequently asked occupational therapists to complete a variety of different tasks. These requests were based upon a loose understanding of the profession and, more importantly, local needs. Occupational therapists, depending on their educational background and personal comfort in the setting, would then decide on individual levels as to whether these skills fell within the scope of practice. As O'Shea and others have highlighted, occupational therapists were often uncomfortable declining tasks, due to an unclear or insecure professional identity. Given such a pathway, it is unsurprising that over the course of the Rehabilitation Era, occupational therapy diversified drastically.

Overall, a synthesis of factors influenced the creation and perception of professionalism in occupational therapy. Factors including gender, power structures, perceived and legitimate control over a knowledge base, and social understandings of the role, each influenced the trajectory of occupational therapy. These factors were not unique to the field of occupational therapy, as other allied healthcare professions experienced similar challenges. Nonetheless, a fundamental absence of societal understanding of the role, scope, and value of occupational therapy has consistently limited its ability to meet all criteria of professionalism. These challenges were highlighted particularly strongly during the Rehabilitation Era, as the transition to public healthcare brought rapid changes to healthcare across Canada that occupational therapists were ill equipped to navigate.

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Table 2: *Occupational therapy program dates.*

School	Year	Location within University	Combined Program Status	Modern Location
University of Toronto	1926	Department of Extension		Department of Occupational Science & Occupational Therapy, within the Temerty Faculty of Medicine
	1950	Within Division of Rehabilitation Medicine within the Faculty of Medicine	Combined from 1950-1971	
	1971	Department of Occupational Therapy within Faculty of Medicine		
McGill University	1950	Department within the School of Physiotherapy within the Faculty of Medicine, in 1951 renamed to the School of Physical and Occupational Therapy	Fully combined 1950-54, partially combined (first two years combined, then chose a field) 1954-71	School of Physical and Occupational Therapy, within Faculty of Health Sciences
Université de Montréal	1954	Within the School of Physical and Occupational Therapy, renamed School of Rehabilitation when SLP was added, earned department status with separation of P & OT program	Combined from 1954-1962	Rehabilitation School within Faculty of Medicine (SLP now has own school)
CAOT	1959	Outside of university setting, employed Queen's professors and sites to teach certain courses	N/A	Moved to Queen's in 1967
University of Manitoba	1959	Department of Occupational Therapy, within the School of Rehabilitation Sciences, within Faculty of Medicine	N/A	Department, within College of Rehabilitation Science, within the Rady Faculty of Health Sciences
University of Alberta	1960	Department of Occupational Therapy within Faculty of Rehabilitation Medicine	N/A	Same location
University of British Columbia	1961	Member of the School of Rehabilitation Medicine	Combined from 1961-83, however students earned	Occupational Therapy was a Division in the School of Rehabilitation

			a diploma (or degree if they chose to do the 4th year, earning a BSR(OT)) in science in rehabilitation. Degree in occupational therapy first offered in 1983.	Science/Medicine, then the School was "disestablished" in 2007 and the Department of Occupational Science & Occupational Therapy (and Department of Physical Therapy) created the same year.
Université Laval	1968	Department of Occupational Therapy within Faculty of Medicine	N/A	Same location
Queen's University	1967	Department of Occupational Therapy within the of the School or Rehabilitation Therapy, within the Faculty of Medicine	N/A	Program, within the School of Rehabilitation Therapy, within Faculty of Health Sciences
The University of Western Ontario	1971	Department of Occupational Therapy within Faculty of Medicine	N/A	Department, within Faculty of Applied Health Sciences
Mohawk College	1977	College level, not recognized by CAOT	N/A	Moved to McMaster University in 1986 From 1981 to 1986, graduates could complete a degree completion program at McMaster to earn a B.H.Sc, though this was not required not permitted registration with CAOT
McMaster University	1986	1989- School of Occupational Therapy and Physiotherapy, 1974 Faculty of Health Sciences established Also facilitated a bridging program for Mohawk graduates from 1980-84 to obtain a Bachelor of		Program, within the School of Rehabilitation Science, within the Faculty of Health Sciences

		Health Science and register with CAOT		
Dalhousie University	1983			School of Occupational Therapy, within Faculty of Health

***Table 2**: Inclusion criteria for oral history interviews.*

Criteria	**Notes**
1. Practiced occupational therapy in Canada between 1950-1985 *and/ or* *2. Attended a Canadian Occupational Therapy or Physical and Occupational Therapy program between 1950-1985*	• Do not need to be presently employed at time of interview • Do not need to have been registered with CAOT • Do not need to have graduated from the program (either before 1985 or at all) • Do not need to have ever practiced as an occupational therapist if attended a P & OT program