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WHAT EVERY PHYSICIAN SHOULD KNOW ABOUT OCCUPATIONAL THERAPY

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Most physicians believe that the use of such unprofessional activities as arts, crafts and workaday skills are so far removed from the language and dignity of remedial prescription that they ignore an area of treatment which can useful and important to their patient. Occupational therapy may be used to hasten physical and functional restoration, provide contentment and even motivation during convalescence and provide the proper direction in the rehabilitation process. In hospitals which have a department of occupational therapy the availability of equipment, material and therapists makes some of the staff physicians conscious of its usefulness and use, but most therapists wage a continuous struggle to interest physicians in its prescription, for as medical specialization grows the specialist focuses on a narrowing area of pathologic conditions while the psychologic and environmental parts of the patient's picture become blurred. At present it is usually the patient or the therapist rather than the physician from whom the request for occupational therapy arises.

There are many ways in which occupational therapy may be used, but for the sake of simplicity. I shall consider them under five objectives: remedial exercise (kinetic), graduation of effort (metric), improvement of tonus (tonic), influence on the mind (psychiatric) and evaluation (diagnostic). Each of these may be and often is tangential or coincident with some of the others.

KINETIC OCCUPATIONAL THERAPY

There are many names for the use of exercise in medicine, the oldest of which is medical gymnastics, the tnost comprehensive but least used, kinesitherapy. Kinesitherapy means treatment by motion, and it is from this concept that I have labeled kinetic that form of occupational therapy used to restore muscle power, increase joint range and improve muscle coordination. This form of treatment was first described and used by Tissot in 1780 but fell into disuse until its resurrection in France during Wor1d War I.

When muscle strength has diminished as the result of disease or immobilization, if innervation is intact or returning, exercise will usually shorten the recovery period. Exercise with or without gymnastic apparatus is usually the treatment of choice, but there are instances in which the execution of motions by means of actual tools or skill-motions is superior. In general it may be said that earliest motions should be occupational and that coordination of the hand and finger motions is best achieved by kinetic occupational therapy. The use of craft tools permits unconscious control of the motion patterns, and by demanding less concentration and offering more pleasure fatigue is forestalled and endurance increased. Specific prescription requires a motor analysis of craft motions in relation to joint range and energy expenditure. Although the physician should have some knowledge of these, the well-trained therapist will frequently know or be able to determine the activity most closely fulfilling the exercise criteria desired. The physician should prescribe duration, frequency, effort and precautions in occupational therapy as in other remedial exercises.

This form of occupational therapy can also be used to mobilize joints and superficial scars, but in almost no instance is occupational therapy an adequate substitute for physical therapy or gymnastics. Few occupational motions carry a joint through its entire range, certainly not as far as passive manipulation or resistance exercises; but since tools may be modified or adapted to fuller ranges or even stretching, occupational therapy should be prescribed to maintain the gains made by physical therapy.

Prolonged immobilization and certain motor neuron lesions result in incoordination. Coordination must be taught to those with cerebral palsy or hemiplegia and to the amputee. Coordination is taught by tedious repetition, and the therapist must have as much patience as the patient has incoordination. The motions of daily living are taught on models which are larger and easier to manage than those encountered in life. As these motions are mastered, finer and more intricate maneuvers are taught with the eventual goal of using ordinary equipment.

METRIC OCCUPATIONAL THERAPY

There are several diseases which require prolonged bed rest but which frequently permit return to partial or complete activity. The most common examples of such conditions are found in cardiac and pulmonary disease, In such conditions return to activity must be gradual. In the past the chief method of measuring and prescribing increased activity was by scheduling progressively increasing daily walks, and this is still a common and useful procedure. Ideally, however, activity should be started in bed. Work may be therapeutic in proper dosage and dangerous in overdosage ; occupational therapy offers a method of measuring and increasing work dosage which is not obvious to the patient. The limit of work dosage is called work tolerance and is determined by such indicators as respiratory rate, systemic temperature and fatigue. Occupational therapy may be used not only to improve work tolerance but to measure its progression and furnish prognostic information. Because this type of occupational therapy is so closely dependent on measurement we have called it metric.

TONIC OCCUPATIONAL THERAPY

Most living tissues or processes which are placed at enforced rest will atrophy in some proportion to the period of disuse. When bed rest is part of treatment those muscles normally used in walking, standing and sitting will lose strength. Not only will muscles lose tonus but manual dexterity and mental processes will slowly deteriorate. Bed rest is especially boring because it demands a position. uncommon to daily

occupations and because, except for passive amusements such as reading or listening to the radio, it is a deterrent to activity. The tone of muscle and mind diminishes, and occupational therapy is almost the only method of obtaining and maintaining the desired level of tone by offering the patient that type of activity most suited to his tastes which will give him maximum exercise within the limits of the disease. Previously this was called diversional occupational therapy, but I have elected to call it tonic because its major function is to restore tone, and it is certainly a more palatable name to physicians. Properly, the term diversional therapy may be limited to the activity which takes the patient's mind off something, such as work which is so absorbing that the patient will forget about an itch or pain.

PSYCIIIATRIC OCCUPATIONAL THERAPY

The ultimate aim of all treatment in psychiatry is to return the patient to the community. For a fairly large number, no treatment yet exists which can accomplish this, For those who must remain institutionalized indefinitely, occupation offers a method of halting or diminishing mental deterioration and of providing sheltered employment so that the elementary work appetite may be satisfied. By daily insistence on habit training and the responsibilities of performance the chronic regressed patient can be maintained at a higher level of intelligence, be less of a disciplinary problem and be easier to maintain hygienically. For the patient who will one day return to the community, occupational therapy offers an opportunity to restore confidence and self respect by accomplishing tasks of increasing complexity, by offering an outlet not only for aggressive tendencies but for creative energy. Occupational therapy offers the opportunity for realistic work and brings the patient continuously closer to communal society by group work and group recreation. Once the patient has been discharged from the hospital, the new skills and hobbies he has learned will have mental hygienic values which will give him less tine for introspection, less boredom to punctuate unsocial ideas and acts.

DIAGNOSTIC OCCUPA'MONAL THERAPY

Occupational therapy can be of great value not only in arriving at a diagnosis of mental disease by observing and recording reactions to work, the environment and companions but can be of prognostic value in nothing the progressive change toward one or another extreme.

It is also of great value as a means of evaluating the suitability of a new job objective. Regardless of his disease or disability, the counselors and physicians may determine that the patient must change his occupation. After a new occupational objective has been determined, the patient may try the basic technics of that position in the occupational therapy clinic, and observers may determine his physical, emotional and endurance suitability.

CONCLUSION

In this outline emphasis has been placed largely on the hospital aspects of occupational therapy in chronic disease.

The practitioner who wishes to give the best possible medical care can and should apply the principles of occupational therapy to the homebound patient.

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