Seeing a Whole Life: Genre and Identity in Occupational Therapy

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SEEING A WHOLE LIFE: GENRE AND IDENTITY IN OCCUPATIONAL THERAPY

by

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B.A. Washington Adventist University, 2001

A thesis submitted in partial fulfillment of the requirements
for the degree of Master of Arts
in the Department of Writing and Rhetoric
in the College of Arts and Humanities
at the University of Central Florida
Orlando, Florida

Summer Term
2015
ABSTRACT

A significant body of writing and rhetoric research focuses on the literate practices that reflect or construct the professional self, particularly in disciplines that rely heavily on the use of forms to categorize or identify customers, clients, or patients. Many of these studies examine the influence of discipline-specific genres on the creation of a professional self for healthcare practitioners. Occupational therapy, a nearly 100-year-old yet little understood profession, is significantly different from many other healthcare disciplines, in part, because the genres used by occupational therapists reflect the profession’s careful attention to the whole life of a patient. These genres are built around an understanding of a patient’s occupation as the object of the profession’s activity system. “Occupation” (commonly defined too narrowly by those outside of the profession as “work”), is, quite simply, anything that meaningfully and purposefully occupies a person’s time. This broadly defined object invites an expansive professional vision that includes the patient’s life and history outside of a diagnosis.

This study presents the narratives of four occupational therapists and the literate activities that inform their practice. Their voices, as excerpted in this case study, join a strong, ongoing conversation in writing and rhetoric studies about the relationship between genre and identity. Using the lens of activity theory, this is one account of a healthcare profession that pays unusual attention to patients’ whole lives through genres that mediate shared agency between the caregiver and patient. It is also, however, the story of the ways in which this identity, as a uniquely occupation-based discipline, becomes obscured as therapists translate their work to genres created and controlled by other, more powerful activity systems.
ACKNOWLEDGMENTS

I am indebted to so many conversation partners who have patiently listened, provided feedback, and encouraged me to complete this project. I am grateful, first, to the members of my thesis committee. Dr. Elizabeth Wardle taught my initial course in this program, where I first came to understand the powerful connection between writing and identity. She has read more drafts, calmed more anxieties, patiently guided more stray thoughts, and done more to help me find my voice in this community than any other single person related to this project. Dr. Mark Hall taught me how to truly listen to other people through work as a writing center consultant. His classroom was also the place where the proposal that eventually became this research project was created, and his guidance has been crucial in seeing it through. Dr. Kevin Roozen is an example of the kind of researcher I hope to be – someone who truly invites participants to guide his professional vision in ways that have shattered my prejudices about what counts as writing. I could not have asked for better mentors.

I am proud to have been able to highlight a profession that I have come to deeply respect – occupational therapy. Chris, Ron, Tia, and Vicki – the four therapists I was privileged to interview – were incredibly generous with their time, their experiences, and their expertise. I am forever indebted to them for allowing me into their profession, and for providing encouragement, as friends and colleagues, throughout this process.

I am grateful, too, for the community of practice that I was able to join as a student in this program. There are traces of every class and every conversation in this document. I am thankful to have been challenged and supported, in particular, by my colleagues John Chrisman, Joshua
Corlew, Yumani Davis, Amanda Jones, Megan Lambert, Melissa Pompos, and Jacob Stewart. It was a privilege to be able to study with such generous and gifted people. Additionally, courses and conversations with Dr. Melody Bowdon, Dr. Stacey Pigg, Dr. Gabriela Raquel Ríos, Dr. Blake Scott, and Dr. Douglas Walls all shaped and challenged my thinking in ways that were crucial to this project.

I am also grateful for my community outside of school – friends and colleagues who allowed work hours, vacations, and dinners to be interrupted and punctuated by questions and conversations about this thesis. I am truly thankful for Alita Byrd, Fiona Ghosn, Paul Gleeson, Dr. David Greenlaw, Ansley Howe, Nina Negretti, Jennifer and Jason Payne, Millie Prado, Dr. Don Williams, and Dr. Karen Studer. I am particularly grateful for Yvette Saliba, my colleague at the university where I conducted my research, and an extraordinary friend who not only spent hours talking with me about these ideas, but who worked with me to implement, in tangible ways, projects on our campus that were born out of these conversations. And, to Dr. Roy Branson who passed away on the day that I defended this thesis. As the first professor to encourage me to continue my education, he spoke my identity as a graduate student into existence.

Finally, I am grateful for my mom and dad, Ann and Kim Johnson. They were my very first conversation partners. They taught me to value curiosity and to respect language, and they have believed, every step of the way, that I had something to say that was worth listening to.
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<th>Full Form</th>
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</thead>
<tbody>
<tr>
<td>AMA</td>
<td>American Medical Association</td>
</tr>
<tr>
<td>AOTA</td>
<td>American Occupational Therapy Association</td>
</tr>
<tr>
<td>CAG</td>
<td>Coverage and Analysis Group</td>
</tr>
<tr>
<td>CCSQ</td>
<td>Center for Clinical Standards and Quality</td>
</tr>
<tr>
<td>COPM</td>
<td>Canadian Occupational Performance Measure</td>
</tr>
<tr>
<td>CPT</td>
<td>Current Procedural Terminology</td>
</tr>
<tr>
<td>OBRA</td>
<td>Omnibus Budget Reconciliation Act</td>
</tr>
<tr>
<td>OT</td>
<td>Occupational Therapy</td>
</tr>
<tr>
<td>PT</td>
<td>Physical Therapy</td>
</tr>
<tr>
<td>SOAP</td>
<td>Subjective, Objective, Assessment, Plan</td>
</tr>
</tbody>
</table>
CHAPTER ONE: BACKGROUND AND METHODS

This thesis presents the narratives of four occupational therapists and the literate activities that inform their practice. Their voices, as excerpted in this case study, join a strong, ongoing conversation in writing and rhetoric studies about the relationship between genre and identity. Using the lens of activity theory, what follows is one account of a healthcare profession that pays unusual attention to patients’ whole lives through genres that mediate shared agency between the caregiver and patient. It is also, however, the story of the ways in which this identity, as a uniquely occupation-based discipline, gets obscured as therapists translate their work to genres created and controlled by other, more powerful activity systems.

Background

A significant body of writing and rhetoric research focuses specifically on the literate practices that reflect or construct the professional self, particularly in disciplines that rely heavily on the use of forms to categorize or identify customers, clients, or patients. Scholars have explored identity as written by, and on, such disparate genres as census forms (Scollon) and archeological maps (Goodwin). In their article “Literacy and Identity,” Elizabeth Moje, Allan Luke, Bronwyn Davies, and Brian Street suggest that, “texts and the literate practices that accompany them not only reflect, but may also produce, the self” (416; see also McCarthy and Moje). Many studies examine the influence of discipline-specific genres on the creation of a professional self for the healthcare practitioner. As Catherine Schryer and Philippa Spoel note, “Rhetorical genre theory provides an especially useful framework for understanding the connections between specific health-care communication practices and the symbolic activity of
professional identity formation in health fields” (252). Literate practices that mediate the
delivery of care include communication between a patient and a healthcare practitioner as well as
between practitioners and the institutions within which they work. For example, Zoe Nikolaidou
and Anna-Malin Karlsson interview caregivers in an assisted living facility to understand, “how
institutional documentation practices influence care-workers’ identity construction” (507). The
authors examine the use of a mandated resident journal, which forces caregivers to adopt the role
of marketers, writing resident experiences in ways that family members find palatable or
comforting.

Rhetorical genre theory also facilitates the examination of literate activity that narrows or
sharpens the identities of both caregivers and patients. In her book *Doctors’ Stories*, Kathryn
Hunter explores how physicians come to see and interpret medical knowledge. She writes,
“Indeed, the physician’s own subjectivity as well as the subjectivity of the patient is controlled
by the fixed conventions of the medical narrative” (xx). In her study of psychotherapists, Carol
Berkenkotter observes the way that the *Diagnostic and Statistical Manual of Mental Disorders*
(DSM), published by the American Psychological Association, establishes parameters of
perception for psychotherapists. She notes that the codes outlined in the DSM organize the
therapist’s sense of the client’s identity, writing, “One can discern traces of DSM-IV’s shaping
activity on the therapist’s inscriptions” (337). Anis Bawarshi notes how the Patient Medical
History Form (PMHF) is “at work on the patient,” perpetuating the prevailing culture by
“socializing or scripting the individual into the role of ‘patient’ (an embodied self) prior to her
meeting with the doctor” (74). Bawarshi indicates that these forms also shape the doctor’s
identity by limiting her vision of, and role in relationship to, the patient. Rita Charon, who heads the School of Narrative Medicine at Columbia University, has written extensively about the ways in which medical record keeping narrows the kinds of information that a doctor will see as relevant or valuable. She writes, “By teaching our students how to tell this type of story, we teach them deep lessons about the realms of living that are included and excluded from patient care. Learning to chart is precisely the process of learning to eliminate individual detail, the life story” (86-87). Hunter echoes Charon’s concern, noting, “The chart is a minimalist account. With its lists and graphs and flow sheets, it is the near-zero condition of medical narrative...Details of character and motivation are suppressed in favor of objective information about physical findings-abnormalities and signifying normalities” (86,91). A consistent thread that runs through these studies is the observation that the genres facilitating the caregiver–patient exchange have the strong effect of bounding this interaction tightly in both time and space. For reasons largely attributed to efficiency, genres such as charts and medical history forms focus the attention of those who use them on the timeline circumscribed by disease processes and the places and tools of treatment.

Nearly all of these studies indicate that while established genres often limit the identities available to both practitioners and patients, these limitations have a practical purpose. Standardized ways of observing and communicating do important work in mediating activities that are particularly complex, including the diagnosis of illness. For instance, Bawarshi writes, “Genres maintain ways in which we perceive particular environments as requiring certain immediate and ‘appropriate’ attention and response” (77). He goes on to write that genre
conventions “allow their users to participate in these environments in meaningful and recognizable ways” (78). Christa Teston observes the use of Standard of Care documents, which are designed to guide decisions about treatment for various forms of cancer. She suggests that professional genres, such as the Standard of Care documents, have four key functions. “They a) draw people’s attention to certain rules and relationships, b) authorize certain ways of seeing, c) stabilize certain versions of reality, and d) set the terms by which future discussions take place” (322). Bawarshi and Mary Jo Reiff also suggest that these functions facilitate the enculturation of new members of a discourse community by defining, “how we come to know and learn, and how we construct, value, and experience ourselves in social time and space” (90).

A significant body of work, therefore, examines genres that mediate healthcare education. Schryer and her colleagues have explored the enculturation of students in medicine, optometry, and social work by examining the way “genres, such as case presentations and policy documents, function as mediating tools in the complex processes of professional identity formation” (250). Julie Apker and Susan Eggly write, “Case presentations turn into self-presentations” (415) that reinforce the identity of the medical resident as “an objective, emotionally distant, scientific authority” (426). In these instances, genres work to both facilitate and create the systems of which they are a part. Bawarshi and Reiff suggest, “subjectivity and identity are bound up in genre knowledge and performance, as we are constantly accomplishing ourselves and our objectives/motives as we enact them through our mediational means” (104).

The genres that mediate the work of many healthcare professionals serve to define a set of tools and identities circumscribed by a specific activity system. David Russell defined an
activity system as “any ongoing, object-directed, historically conditioned, dialectically structured, tool-mediated human interaction” (510). This theoretical lens, derived from Yrjö Engeström’s work (1987), is often portrayed in a range of studies as a triangular, interactive set of nodes. In most cases, these nodes are labeled with some arrangement of tools, subjects, rules, communities, division of labor, objects, outcomes, and motives (as illustrated below).

Figure 1: Activity System

The activity system for most healthcare providers is very tightly defined. Where the subject is the practitioner, for instance, tools like patient charts and case presentations often work to identify the object as abnormalities, diagnoses, or diseases (rather than people). In turn, this constructs the caregiver as the expert who acts on the disease with tools for the specific purpose of eliminating the abnormality.
The theoretical lens of the activity system is particularly useful for conceptualizing the ways in which healthcare practitioners interact in writing with other professions – other activity system. In these cases, genres that may be generated and controlled by one profession also function to mediate activity and identity in another. For instance, Hunter examines the ways that the objects of legal activity systems influence the patient chart, resulting in conventions like the use of collective pronouns as well as a cool, detached tone (91). In discussing the run report, a genre used by emergency medical technicians, Roger Munger highlights the influence of external actors (physicians, attorneys, etc.) on these documents, writing, “The needs of the legal profession made the run report a legal artifact as well. Providers were often reminded in training sessions that ‘if you don’t write it down, you didn’t do it’” (335).

In these cases, the writing completed by a caregiver is intended almost entirely for the purposes of another profession. The caregiver becomes a scribe, writing her identity in the language of a different activity system. And, in such instances, conflicts between distinct activity systems can emerge. Engeström identifies these conflicts as “contradictions” – moments when there is tension between the preferred objects, tools, or outcomes associated with differing systems. Terttu Tuomi-Gröhn and Engeström suggest that, when faced with such contradictions, practitioners have some opportunity to fashion tools that can bridge conflicting activity systems, writing, “Numerous studies demonstrate the centrality of symbols, technologies, texts, or systems of artifacts in constructing continuities and transformations across social situations” (27). Etienne Wenger characterizes these social situations in terms of the boundaries between what he defines as communities of practice. Wenger notes that artifacts, including genres, travel
between such communities by way of an actor that he labels a “boundary broker” - someone who has authority, and perhaps even membership, in both communities. This, however, is not always possible. Conflicting communities very rarely share power equally, and they even less frequently recognize the same brokers and artifacts as authoritative.

Occupational therapy is a nearly 100-year-old healthcare profession that is often misunderstood by those systems with which it must communicate in order to accomplish its goals. This is largely because the objects, tools, outcomes, and rules that define this discipline are significantly different than those that define many other healthcare professions. For instance, occupational therapists identify the entire person, not just a disease, as the object of their activity system, and the profession’s tools of choice are derived from human occupation – quite simply anything that occupies a person’s time. A therapy session may, then, appear to an uninformed observer to resemble a crochet class or a basketball game as the therapist works to return people to those activities that gave life meaning before an accident or illness made participation in these activities difficult or impossible. The inclusion of these tools has the effect of opening up the occupational therapy activity system to nearly any time or space in the patient’s life, and the genres that mediate this system are almost unlimited, ranging from standardized assessments to games and worksheets customized for a specific patient.

Several unique conflicts have also resulted from this broadly defined activity system. Bawarshi and Reiff note that genre systems work to “define the limits of our agency” (90). For occupational therapists, many of the genres used for evaluation and treatment define a shared agency with the patient. This, coupled with the use of treatment tools that may be considered
“commonplace” (for instance, crafts and leisure activities as opposed to MRI machines or pharmaceuticals), has resulted in a professional identity crisis. Annual conference proceedings, journal articles, and textbooks often include concerns about the viability of the profession as a health science. This anxiety, in part, has led to participation with other activity systems, including third-party payers such as Medicare, which privilege disease as the primary object and do not recognize participation in leisure activities, for instance, as viable goals for treatment. Over the past several decades, the profession and its professionals have made both unsuccessful and successful attempts to broker across the resulting boundary conflicts in cases where they have neither authority nor membership in any system other than their own.

**Study Design**

I explored the literate practices of occupational therapists through a qualitative case study, conducted at a small health-sciences university in Central Florida. I interviewed four occupational therapists, all of whom also teach at this university, in order to explore the following research questions:

1) What genres are used most frequently by occupational therapists, and how do these genres mediate activity for these practitioners?
2) What genres or genre sets accompany, or work in tandem with, the forms used by practitioners?
3) How is the identity of the profession reflected and/or impacted by these genres?
4) What is the relationship between the profession’s discussion of genres and the use of genres at the level of the individual professional?

**Participants**

Tia is the Chair of the occupational therapy department at the university where she also teaches as a full professor. She has been a practicing occupational therapist for more than twenty
years in settings ranging from inpatient rehabilitation hospitals to public schools. Tia serves on the Accreditation Council for Occupational Therapy Education and has written chapters in occupational therapy textbooks. She also started and manages a free occupational therapy clinic affiliated with the university that serves uninsured and underinsured members of the community.

Vicki has been a practicing occupational therapist for twenty-four years and an assistant professor of occupational therapy for sixteen years. Her specialty is with older adult and mental health populations. Vicki is an Authorized Allen Cognitive instructor – an assessment developed by occupational therapists – and, as such, presents nationally on topics related to cognitive assessment and treatment. She also recently contributed a chapter on the topic of documentation to the forthcoming textbook *Foundations of Theory and Practice for the Occupational Therapy Assistant*.

Chris has been an occupational therapist and therapy manager for thirty-two years, and is currently an associate professor at the university. Chris has practiced and managed therapy in a wide range of settings, particularly in skilled nursing facilities, and she served for eight years as vice-chairperson and chairperson of the Maryland Board of Occupational Therapy Practice, an organization that manages changes, and adherence, to the profession’s state scope of practice. Early in her work with the Board, Chris reviewed complaints made against occupational therapists for providing treatment outside the scope of practice.

Ron has been a practicing occupational therapist for nearly twenty years, and is an assistant professor of occupational therapy at the university. He has worked in skilled nursing and rehab settings, and he owned and managed his own private practice. Ron, along with Tia,
started a free clinic at the university, and Ron served as the first manager of the clinic. Additionally, Ron helped to develop the documentation used in the clinic at its inception.

I have interacted professionally, as an employee of the same university, with each of the participants for varying lengths of time. I have known Tia and Vicki for eight years, Ron for four and a half years, and Chris for one. This pre-existing working relationship may have allowed our conversations to include concerns and experiences offered by the participants only because of the trust established before this study. This has almost certainly also resulted in some bias. However, as Prior has noted, in tracing his daughter’s path to becoming a biologist, researcher-participant relationships that pre-exist a formal study can enrich the available data set significantly.

I collected interview data from the four study participants in order to explore the questions of this study. Additionally, I reviewed assessment and treatment forms, textbooks, articles, and additional documents in order to provide context for the interviews and subsequent data analysis.

Data Collection

I completed twelve hours of interviews with the participants. These interviews were guided by the following questions:

1) Questions about the therapist’s background:
   
   How did you decide, initially, to become an occupational therapist?
   What do you enjoy most about your work?
   What do you enjoy least about your work?

2) Questions about the therapist’s education:

   How/Where did you learn to complete the documentation relevant to your work?
What, of those things that you learned in school, do you feel you apply regularly in practice?

3) Questions about the use of documentation:

What percent of your work is spent in filling out documentation?
What informs your choice of forms or documentation?
What makes a form or documentation practice useful?
Have you ever created, or wished you could create, your own documentation? Why?
   Why not?
Can you talk me through some of the most common forms/documentation that you use?
   What are the sections of such forms?
How do you decide what to write in each of the sections?
How much of the information on the form is generated by you, and how much is generated by your client/patient?
How much flexibility do you have in completing this form?
Who reads these forms?
How does what you write in these forms impact the treatment plan for a particular client?
Have you changed the forms or documentation practices that you use most frequently over the course of your career so far? Why? Why not?

These questions were used to initiate conversation, but as the participants offered documents or topics for discussion, subsequent interview questions traced these new topics. I also collected artifacts from the participants, and used these artifacts to guide follow-up interviews. The artifacts offered by the participants included:

- Completed patient files, including evaluation forms, treatment notes, assessment tools, handwritten notes taken by the therapist, photographs, funeral programs, doctor’s orders, and discharge papers
- Books that participants offered as meaningful to their own practice (largely textbooks)
- Articles from the profession’s journals and practice newsletters that the participants offered as meaningful to their practice
- State scope of practice documents
- Papers written by one participant during doctoral studies
- Guidelines published by staffing organizations and rehabilitation sites regarding documentation practices
I was also given the opportunity to be evaluated by one of the participants using the Allen Cognitive Level Screen, and I recorded audio of the process and obtained pictures of the tools used in this assessment.

Occupational Therapy Documents and Materials

In order to gain some exposure to the talk and texts about genre and identity ongoing in the profession’s national accrediting and licensing organizations, I read work delivered or published via the channels (conferences, journals, textbooks) established by the American Occupational Therapy Association (AOTA). I read every Eleanor Clarke Slagle Lecture, the keynote lecture delivered by an invited occupational therapist at the national AOTA conference. This lecture has been delivered nearly every year, with few exceptions, since 1955. Named after one of the profession’s founders, the lecture “honors an AOTA member who has creatively contributed to the development of the body of knowledge of the profession through research, education, and/or clinical practice” (aota.org). Additionally, I conducted a search for “documentation” and “identity” in the last fifteen years of the American Journal of Occupational Therapy, the profession’s flagship peer-reviewed publication, and read the resulting fourteen articles. I also read the existing three versions of the Occupational Therapy Framework: Domain and Practice, a document published by the American Occupational Therapy Association to “describe the domain that centers and grounds the profession’s focus and actions, and to outline the process of occupational therapy evaluation and intervention.” Finally, I read the following textbooks, recommended by the research participants: Documentation Manual for Writing SOAP Notes in Occupational Therapy (Borcherding), Willard and Spackman’s Occupational Therapy
(Crepeau, Cohn, & Schell), and Documenting Occupational Therapy Practice (Sames). This reading in the profession, in addition to relevant composition and rhetoric literature, was conducted before and during the interview process in order to guide questions for participants and to provide context for understanding participant responses.

Data Analysis

All participant interviews were audio-recorded and then reviewed multiple times in order to identify themes. I took initial notes while reviewing the audio files, and wrote short “invention papers,” or field memos during data collection to summarize and organize each interview session. I also created edited audio files of interview clips that spoke to a particular theme (“occupation,” “translation,” etc.). Audio and written notes were then organized into categories, and segments selected as representative of these categories were transcribed.

Transcribed interview data was coded using what Johnny Saldaña refers to as “in vivo” coding. Saldaña writes, “The root meaning of ‘in vivo’ is ‘in that which is alive’ and refers to a code based on the actual language used by the participant” (99). Here is one example of such coding:

Table 1: Coding Example

<table>
<thead>
<tr>
<th>Code: “Driven By Insurance”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description: Participants describe the ways in which third-party payers impact practice</td>
</tr>
<tr>
<td>Participant</td>
</tr>
<tr>
<td>Ron</td>
</tr>
</tbody>
</table>
Chris  
“It’s all based on reimbursement. Sometimes managers don’t take into account what the patient can actually do. The more minutes you get, the more reimbursement you get.”

Vicki  
“I remember getting on my first internship, and I remember when someone was getting ready to be discharged and they needed DME [durable medical equipment] and they said, ‘We have to check their insurance,’ and I was like ‘What? I don’t want that to be a thing. Why is there a chance they might not get what they need?’

Tia  
“Medicare wouldn’t reimburse for that because they don’t understand that. So, in my notes I have to play the game about not making it look like we were playing a game.”

These themes and codes were developed recursively, in conjunction with the data collection so that I could both ask questions that tested the boundaries of the categories as well as recognize the emergence of regularities. The written draft was then shared with the participants to request feedback on the accuracy of both the specific quotes included and the themes and narratives identified. The resulting feedback is incorporated in the submitted draft of this document.

Activity theory was a particularly important lens through which to view the narratives that the occupational therapists shared. Working to understand the interactions between therapists and patients, or therapists and third-party payers, in terms of the tools, subjects, objects, division of labor, communities, and rules that informed each of these systems brought into focus the themes, conflicts, and roles described in the chapters that follow here. And, cultural historical activity theory highlighted the role that time and space plays in these systems, which also became a key to understanding how genres mediate practice in occupational therapy.
Study Limitations

This is a case study and, as such, represents only a small number of occupational therapists. However, while these participants were chosen based upon availability and willingness to participate, they represent a wide range of practice sites and patient populations most relevant to occupational therapy practice as well as a range of administrative, instructional, and professional service experiences and posts. I am not suggesting that these case studies can be extrapolated to the entire occupational therapy population. However, this small group is more broadly representative of roles available to members of this profession than the small number of interviewees might imply.

Constraints associated with the practicalities of finishing the thesis genre within the time and space allotted have resulted in the intentional exclusion of a large amount of interview data, including data that explores the personal histories of the participants introduced here. Because a significant amount of time is spent in this thesis emphasizing the importance of occupational therapists’ attention to the whole lives of their patients, the inclusion of these therapists’ personal histories, outside of the practice of their profession, seems an important way to honor their identity in this study. That data set presents an opportunity for future expansion of this draft.

Organization

This thesis, like occupational therapy itself, departs from a traditional format (literature review, methodology, findings, and conclusion). This choice is an intentional effort to more fully represent the narrative nature of the research approach as well as the resulting data. Much of the data presented here outlines the ways in which discipline-specific genres used in occupational
therapy and other healthcare professions have the effect of narrowing the field of vision – creating both efficiencies and blind spots. I am cognizant of the fact that the genre of the thesis has the effect of doing this very thing – narrowing the field of vision by translating data from its original form to a series of sections recognizable as a genre “in partial fulfillment of the requirements” of an M.A. degree. This is certainly true as interviews are transcribed and stripped of tone, body language, and emotion. My ability to retain these original elements of my conversations with the occupational therapists who participated in this study are limited – aside from including original audio clips in my defense, which I did. However, within the available formatting parameters, I am choosing to take a narrative approach to my thesis document in order to retain some sense of the story that I felt the occupational therapists were telling about their work and their profession. In a Slagle Lecture given by Florence Clark, she refers to her work as “Occupational storytelling.” It is my goal to present this data in such a way that, as far as possible, remains true to this identity. As such, I have organized the presentation of my findings into three chapters (outlined below), each of which follows a narrative thread or idea that appears across interviews with all four of my participants.

**Overview of Remaining Chapters**

In the chapters that follow, I attempt to trace occupational therapy identity, and selected related genres, from the creation of genres within the profession’s own activity system, through conflict with a related activity system, and finally through attempts to broker agreement between these conflicting systems.
In chapter two, I provide a brief introduction to occupational therapy as a profession, including some of the genres that mediate the profession’s activity and communicate the values of the profession. These values include a unique focus on “occupation” that allows the patient a great deal of agency and participation in drawing the boundaries of practice to include times and places that exist outside of, but impact, the current diagnosis. I argue that the genres used by occupational therapists reflect the attention that the profession pays to the whole life of its patients.

In chapter three, I describe the conflicts that have emerged between the occupational therapy activity system and third-party payer systems, including Medicare. I argue that the translations occupational therapists make from their own genres to the genres of activity systems with which they are in tension have a significant impact on the identity of the profession and, by extension, material consequences for the profession in practice.

In chapter four, I describe two attempts to communicate across activity system boundaries in ways that preserve the objects, tools, and outcomes central to the practice of authentic occupational therapy. The first attempt, made by the profession’s national membership organization, the American Occupational Therapy Association, has been largely ineffective. However, the second attempt, made by a single occupational therapist through the use of the genre of appeal letters, has been far more successful. In addition to the lens of activity theory, I also employ Wenger’s concept of brokering to examine these two different attempts to write back to the powerful communities that act upon occupational therapy. I argue that the most successful brokers utilize a method that mirrors the approach occupational therapists take to
treatment – the creation of a highly individualized genre that adopts the tools of a conflicting community of practice while remaining focused on original, authentic values.

Finally, in chapter five, I discuss the possible implications of this work for teaching and advocacy in composition and rhetoric.
CHAPTER TWO: EXPANSIVE GENRES AND LAYERED IDENTITY IN OCCUPATIONAL THERAPY

Occupational therapy is unique among other healthcare disciplines, in part because of the profession’s attention to the whole lives of patients. This approach is mediated by a discipline-specific definition of “occupation” (commonly misinterpreted as “work”), which is, quite simply, anything that meaningfully and purposefully occupies a person’s time. Therefore, occupational therapists work toward outcomes as diverse as cooking dinner, playing sports, and dressing without assistance. And, as a result, their tools are often familiar to their patients, and can include anything from frying pans to basketballs to buttons. The practice of occupational therapy, then, has as its objective the restoration of patients to participation in preferred occupations. This approach stands in contrast to more widely recognized healthcare disciplines, such as medicine, nursing, and physical therapy, all of which focus more closely on disease and treatment. These professions create and employ tools that are intended to achieve the primary objective of treating a diagnosis. The genres used to mediate evaluation and treatment in these disciplines focus the attention of their users in ways that reflect the values of each profession, and for many healthcare professions, this focus is limited to the time and space associated with an illness. In this chapter I argue that the genres used by occupational therapists reflect the profession’s unique and careful attention to the whole life of the patient.

Genres as Professional Frames

Genres-in-use play a powerful role in the professionalization of new initiates to a discipline. Charles Goodwin, for instance, discusses how genres, functioning as professional
tools, frame the way that new archaeologists view an archeological dig. These tools, he observes, have the effect of creating what he refers to as “professional vision.” For instance, Goodwin describes a chart that provides archaeologists with standardized descriptions of dirt color at an excavation site. Goodwin writes, “By using such a system, a worker views the world from the perspective it establishes...They engage in active cognitive work, but the parameters of that work have been established by the system that is organizing their perception” (609). In the case of these archeologists, the tools that shape the professional vision of new members are tools generated or selected for use by the profession itself. They are artifacts that, when used in practice, define both the nature of the practitioner’s work and, by extension, her professional identity.

In the case of archaeologists, tools like the color chart suggest ways of viewing the world that are consistent with a set of discipline-specific labels or categories. Tools can also have the effect of excluding certain data, people, or objects from consideration. For instance, in his work “Do Artifacts Have Politics,” Langdon Winner suggests that artifacts, or tools, can be created for the specific purpose of exclusion. He uses, as an example, the low-hanging overpasses built by Robert Moses, master builder of public works in New York for much of the 20th century. Moses himself indicated that these overpasses were constructed at a height of ten feet specifically to make travel into New York City impossible for twelve-foot buses, the transportation of choice at the time for minority and low-income populations. Winner writes, “To our accustomed way of thinking, technologies are seen as neutral tools that can be used well or poorly, for good, evil, or something in between. But we usually do not stop to inquire whether a given device might have
been designed and built in such a way that it produces a set of consequences” (125). Tools, Winner illustrates in multiple examples, have practical, material consequences as they not only shape information, but also exclude people or data from consideration.

A number of writing and rhetoric scholars have noted the ways in which genres can have this shaping and filtering effect. Schryer argues that one important way that genres inform professional vision is through the manipulation of time and space. She writes,

When we address the issue of genre and power, we also need to explore a genre’s relationship to time and space, not just in terms of its relationship to the past, present, or future, but most importantly in terms of a genre’s attempt to control time/space by defining what categories of time/space are at work within specific genres (84).

Schryer is joined by a number of researchers who note the important relationship of a genre to the chronotope it creates or sustains. In his work, “Place, Pace, and Meaning,” Jay Lemke writes, “Our actions in every present moment are only possible because of the affordances of material artifacts and conditions...The semiotically mediated bearing of the past on present events creates heterochrony, an interdependence of short-term events and long-term trends and projects” (119). Lemke uses a cathedral as an example, which is a structure that simultaneously bears traces of an extended history while also providing space for individuals at any moment to experience the cathedral both as a text of memory and an artifact of worship, tourism, or any number of fleeting practices and experiences. Genres act, in many systems, like the cathedral – mediating current activity, in part, through a controlled presentation of past events.

Much depends, however, on which elements of the past are selected to mediate the present. Genres consolidate a history of dialogue – of trial and error – into a tool that provides users with the best practices and priorities that survive this exchange. It is possible to make a
Darwinian assumption that the areas of focus established by a widely used genre represent the most evolved, most useful version of disciplinary practice. However, Goodwin closes his article about professional vision with a warning against such assumptions. Goodwin calls members of any profession to “hold each other accountable for – and contest – the proper perception and constitution of the objects of knowledge around which their discourse is organized” (628).

Genres as Frames in Healthcare

These considerations are particularly relevant to the genres used as tools by healthcare practitioners. Julia Epstein studies case history forms, a genre commonly used by physicians. She notes:

No form of writing can ever be neutral...For medical records to serve any epistemological purpose, they need to rely on biomedical systems of explanation that, in turn, empower physicians to create a sequential history, to subordinate or suppress some factors while emphasizing others as they recount their patients’ stories of illness and turn them into cases of disease” (42 – see also pp. 54 and 55).

The patient medical record is designed like the low New York overpasses – namely, to determine what factors in the patient’s history come through, so to speak, to mediate the patient/caregiver interaction. For instance, in most medical records, such as charts, only those elements of the patient’s life that can be tied to a particular disease are recounted on the form: vital signs, weight, symptoms, current medications, etc. The “History” section of any such record rarely strays far from the current complaint, as this history is largely an account of the disease. It is, in large part, this tightly defined chronotope that works to eliminate the person in pursuit of the disease.

Schryer notes the dangers of such restrictions, writing, “Genres are forms of symbolic power and
could be forms of symbolic violence if they create time/spaces that work against their producers’ and receivers’ best interests” (84).

In her book *The Body Multiple*, Annemarie Mol suggests that disease itself is the creation of a medical practice that cuts the body off from a phenomenological narrative or history. Mol writes, “There is a certain economy in isolating objects from the practices in which they are enacted. When the intricacies of its enactment are bracketed, the body becomes established as an independent entity. A reality all by itself” (36). This practice of translating people into diseased bodies is mediated by genres that not only constrict time, but also dissect the body with language. In some cases, these genres even include a rough outline of the body, and the practitioner can simply place an “x” in the area of the patient’s complaint. In fact, in order to stake out the boundaries of their domain of practice, certain professions may include, in their scope of practice documents, a list of body parts or regions that fall under their professional jurisdiction. Physical therapists, for instance, are widely understood to be “lower body” specialists. This means that, by default, occupational therapists are often confined to the upper body. Ron indicated, after reading a draft of this chapter, that divisions like this one can be traced back to reimbursement. He suggests, “I think it’s just a money issue, so that PT and OT can see the same patient without overlapping on billing.” This division is frequently reflected in genres created at practice sites that must manage the work of a wide range of therapists (physical, occupational, speech, etc.). The example reproduced below is a genre that is included in a textbook used to teach occupational therapists about documentation that they might expect to encounter in a variety of practice settings. This genre is labeled, “Occupational Therapy Initial
Evaluation...Courtesy of Capital Region Medical Center, Jefferson City, MO.” The excerpt in the figure calls for data on “Upper Extremity Range of Motion (ROM) and Strength.” There is no corresponding set of responses required from the occupational therapist regarding the patient’s lower extremities.

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| Wears glasses                  |          |    |    |
| Dentures                       |          |    |    |
| Hearing                        |          |    |    |
| MUSCLE TONE/UPPER EXTREMITIES  |          |    |    |
| Hypotonic                      |          |    |    |
| Normal                         |          |    |    |
| Hypertonic                     |          |    |    |
| Comments                       |          |    |    |
| UPPER EXTREMITY SENSATION      |          |    |    |
| Sensation                      | Intact   |    |    |
| Impaired                       |          |    |    |
| Absent                         |          |    |    |
| Light touch                    |          |    |    |
| Sharp/Dull                     |          |    |    |
| Temperature                    |          |    |    |
| Proprceptual                   |          |    |    |
| Stereognosis                   |          |    |    |
| COORDINATE/UPPER EXTREMITIES   |          |    |    |
| Tremors                        | Apaxia   |    |    |
| Ataxic                         |          |    |    |
| Impaired                       | WNL      |    |    |
| Gross Motor                    |          |    |    |
| Fine Motor                     |          |    |    |

Figure 2: Occupational Therapy Initial Evaluation...Courtesy of Capital Region Medical Center, Jefferson City, MO

The upper body/lower body distinction is not the only attempt by health professions to carve out territory by owning sections of human anatomy. Chris describes another such delineation that has been forwarded by speech therapy:

Swallowing and feeding is an area of practice shared with speech, and sometimes it gets territorial...It’s one of those things that they somehow took ownership of. So, in most places now, OT is in charge of putting the food in the mouth – like helping people with adaptive equipment and feeding techniques to get the food in the mouth. That’s our part. But once it’s in the mouth, it’s Speech’s part – to manipulate the food and teach people how to swallow it.

This emphasis on anatomy separates the patient’s body from the practices in which a person engages outside of the hospital or before a diagnosis. In the only study published jointly to-date
by a composition scholar and an occupational therapist (Jane Detweiler & Claudie Peyton, respectively), the authors note the limitations established, in part, by the use of written tools that very closely define a professional field of vision by anatomical boundaries. Further, they indicate that these physical boundaries also serve to constrict time. They write, “In a profound sense, any scientifically precise word, type, concept, or structure implies a closed emplotment that determines actions by infallibly predicting them; thus, in the Bakhtinian sense, a scientific narrative stops time” (Detweiler and Peyton, 420).

This is where the focus of occupational therapy on human occupation is in clear contrast to the object outlined by other healthcare professions. Occupation as object allows a person to be located in the context of places and times outside of her current diagnosis, and the resulting activity system expands to include the whole life of the person.

**Occupation as Object**

Ron explains that, to an outside observer, physical therapy (a profession with which occupational therapy is often confused) and occupational therapy can seem very similar because they both, as he puts it, “work on body parts.” However, occupation, he says, is the key to occupational therapy’s unique identity as a profession:

I believe that human occupation is what OTs own. It is the only thing that we do that nobody else touches. Nobody else understands it, nobody buys into it, nobody does it, nobody believes in it. Yet, occupation is exceedingly important to people...all those things are what makes us who we are. But, within medicine, nobody really addresses the occupation...I believe that is our bread and butter...[But] occupation-based treatment requires time - you’re really trying to understand from the patient’s perspective what is important to them, why it is important to them, and then figuring out what you are going to do, as a therapist, to make that important item more doable for the patient.
When I asked Ron how he defines occupation, he went to the bookshelves in his office and pulled out a worn text called *The Meaning of Everyday Occupation* by Betty Hasselkus. Ron uses this book in the Introduction to Occupational Therapy course that he teaches annually. Included below is an excerpt from this book along with Ron’s notes in the margin.

![Image of a page from a book with handwritten notes]

Figure 3: Excerpt from *The Meaning of Everyday Occupation*

Both the excerpt, which defines an “occupational view of health,” and Ron’s notes highlight the tension between the anatomical object of other health professions and the “lived experience” that is the object of the occupational therapist’s work. Ron’s note even mentions the upper body focus (“the arm”) that is sometimes ascribed to occupational therapy in documentation.

Ron’s perspective resonates with the profession’s published documents about occupation. The American Occupational Therapy Association (AOTA) Commission on Practice publishes a
scope of practice document, which outlines the domain of occupational therapy practice. This domain rests on a broad understanding of the word “occupation.” The document reads, in part:

The domain of occupational therapy is the everyday life activities (occupations) that people find meaningful and purposeful...The occupations in which clients engage occur throughout the life span and include

- ADLs (self-care activities);
- IADLs (activities to support daily life within the home and community that often require complex interactions, e.g., household management, financial management, child care);
- Rest and sleep (activities relating to obtaining rest and sleep, including identifying the need for rest and sleep, preparing for sleep, and participating in rest and sleep);
- Education (activities to participate as a learner in a learning environment);
- Work (engaging in remunerative employment or volunteer activities);
- Play (activities pursued for enjoyment and diversion);
- Leisure (nonobligatory, discretionary, and intrinsically rewarding activities);
- Social participation (the ability to exhibit behaviors and characteristics expected during interaction with others within a social system) (“Occupational Therapy Practice Framework” S4).

This domain, which is a list of nearly everything a person does, could be understood as the object of the occupational therapy activity system. Occupational therapy may be conceptualized, therefore, as a system that takes, as its own object and tools, those objects and tools that are also part of a patient’s activity system. Of particular importance is the fact that this overlap occurs between a specific occupational therapist and a specific patient. The objects (occupations) and tools that mediate the interactions between these systems are not generic. And, this specificity is found in the history of the patient’s life outside of the disease. This often means that the patient/therapist exchange is a moment that is mediated by documents that combine information from the patient’s past (what he or she used to enjoy doing before their illness or injury) and
from the patient’s future (what he or she hopes to be able to do after the illness of injury) with the therapist’s training and expertise.

This expansive chronotope is largely defined by the unusual use that occupational therapists make of the patient’s interests while developing treatment goals. Many of the Slagle Lectures highlight the centrality of the patient’s whole life as a defining practice for the identity of occupational therapists. For instance, in the 1966 Slagle titled “Authentic Occupational Therapy,” Elizabeth June Yerxa argues, “Authentic occupational therapy is based upon a commitment to the client’s realization of his own particular meaning” (138-139). In the 1983 Slagle Lecture, entitled “Clinical Reasoning: The Ethics, Science, and Art,” occupational therapist Joan Rogers declared, “Ethical decision making requires the therapist to search for an understanding of the patient’s life rather than to make an evaluation of it. This understanding facilitates the selection of options to be discussed with the patient” (344). Ten years later, Florence Clark delivered a Slagle lecture that emphasized the importance of understanding a patient’s life – particularly the life outside of the diagnosis. The talk, entitled, “Occupation Embedded in a Real Life,” was largely an extended story of one of Clark’s patients – Penny, a university professor who suffered a massive, debilitating stroke. In her address to the AOTA, Clark made a point of detailing her patient’s biography – her life both before and after the stroke – beginning, in fact, with the patient’s birth. Clark refers to her use of Penny’s history to inform her treatment choices as “occupational story making and occupational storytelling.” Clark writes,

Occupational science assumes that adult character and competence are shaped through childhood occupations. Another way of describing the process, based on the work of French philosopher Foucault, is to think of the self as formed, in part through its history of activities and conduct. It is not enough, he believed, to focus on the symbolic systems,
the person is ‘constituted in real practices—historically analyzable practices’...A crucial element of the re-composition process was to ground the work in Penny’s occupational historicity” (1074).

In this way, the practice of occupational therapy is, in part, the work of historians, reconstituting the identity of their patients by making personal narratives visible through the work of diagnosis and treatment. The identity of occupational therapists is expressed in the literate practices that mediate this identity work with their patients. In his 1999 Slagle Lecture entitled “Defining Lives: Occupation as Identity,” Charles Christiansen concludes his lecture by explaining this very connection:

The work of therapy involves identity building. Therapy becomes identity building when therapists provide environments that help persons explore possible selves and achieve success in tasks that are instrumental to identities they strive to achieve, and when it enables them to validate the identities that they have worked hard to achieve in the past. There is much opportunity for occupational therapy as a special and unique service that provides opportunities for people to establish, maintain, or reclaim their identities...Biomedicine will experience many great advances in the years ahead. But no genetic code, no chemical intervention, and no microsurgical technology will be invented to repair broken identities and the assault on meaning that accompanies them (593).

The Open Genres of Occupational Therapy

Because occupational therapy is built upon attending to each individual patient’s occupation, the genres used to evaluate and treat patients expand the practitioner’s vision to see a broadly defined chronotope. Genres that turn attention to a patient’s whole life reflect a recurring theme in the occupational therapy literature about the central role that patients play as participants in their own healing. As such, the genres available to, and created by, occupational therapists are diverse, offering practitioners an unusually flexible set of tools for use in patient evaluation and treatment. One assessment genre is a particularly good example of the ways in
which the unique identity of occupational therapy is produced and practiced in the literate activities of the profession. This genre, called the Canadian Occupational Performance Measure (COPM), is one of many tools developed by occupational therapists to represent the profession’s unique approach to documentation. The website dedicated to the Measure describes it in this way: “The COPM process is an open dialogue between client and therapist, each bringing their own expertise and perspective to the conversation. The COPM’s flexibility allows the therapist considerable leeway to ensure the tool works best for the situation.” Particularly striking is the indication that this genre is a process that recognizes and incorporates the expertise that both the client and the caregiver have to offer. This is apparent in the measure itself, excerpted below.

![Figure 4: The COPM Front Page Scoring Instructions](image)

![Figure 5: The COPM Back Page Scoring Instructions](image)

The practitioner who uses the COPM allows the client to determine what the object of the therapist’s attention should be. While reading a draft of this thesis, Ron placed a comment in the
margin next to the preceding sentence. He wrote, “BINGO!!!!!!!!!!!!!!! THIS is what should separate OT from others. In a perfect world, the patient determines the problem.” This enthusiasm for the centrality of the patient is reflected in a genre like the COPM. The client generates nearly all of the data in this measure. Scoring is driven not only by performance, but also by satisfaction – both of which are assessed by the client. For instance, the client may score her current ability to dress without assistance low in terms of performance, but also low in terms of importance. The therapist focuses on those occupations that the client identifies as both poor in performance and high in importance.

Occupational therapists also make frequent use of genres that have almost no parameters. For instance, treatment notes are often taken in narrative form, mediated by simple lined notepaper or open-ended questions with ample space for qualitative response. This kind of genre promotes a nearly unobstructed professional vision, allowing the occupational therapist to treat the whole patient on her terms. An example of an excerpt from one such genre produced by Ron is included below. In this case, Ron was working with a patient who had a severe stroke. He visited her in her home where he conducted all of their therapy sessions. The patient was in her late thirties, but the stroke left her unable to walk, or to leave a chair without assistance. In talking with the patient and her family members, Ron discovered that the patient’s self-identified goal was to bake a cake for her husband. He says:

And here we run into that collision of occupation and medicine – that is not medically relevant to anybody that she baked a cake other than, maybe, somebody that’s looking at strength or weakness or something like that. But for me, as an OT, it is exceedingly – probably one of the greatest things ever, you know, that she was able to bake a cake for her husband.
Ron wrote objectives for his client based on this occupational goal. His notes from one session follow:

![Figure 6: Treatment Note About Meal Preparation (Ron)](image)

The genre simply requires that the occupational therapist identify problems, interventions, and outcomes, all of which are written from the perspective of the patient’s expressed goal to prepare a meal. This kind of note resulted in challenges from other practitioners to Ron’s treatment choices, because his practice includes work that might be interpreted as crossing over into physical therapy’s domain – the lower extremities and related mobility. Washing dishes requires standing, and the outcomes listed above begin with an indication that the “Pt [patient was] in/out kitchen,” with the use of a walker (RW), something that requires ambulation. When I asked Ron about this, he responded:

Words matter, because mobility-related ADLs [activities of daily living] ah, means you are using a mobility device whether it’s a wheelchair, walker, cane, crutches, or nothing to do daily activity. So, getting your clothes out of the closet, getting to the bathtub, getting in the bathtub, getting in and out of the shower, going to the car, getting in the car, all that stuff involves mobility. So, that’s clearly within our scope of practice, and that is – I believe strongly, GRRR, strongly – that that is an area of expertise that I have that nobody else has because I understand the importance of human occupation and I
understand the psychosocial demands, the environmental demands, the physical demands and so I see, in theory, the bigger picture.

For Ron, the patient’s occupational goals supersede the anatomical boundaries imposed by the scope of practice documents from other professions. However, he has had to defend his choice of tools and approaches. He remembers:

[I have had] the state practice act in hand to show that I could do this type of stuff, and it just caused so much grief. But again, this is – this is occupation. This is what’s keeping her from doing her occupation is she can’t get from point A to point B. She can’t push a wheelchair.

Adopting a specific patient’s chosen occupation as the object of the occupational therapy activity system means that almost any tool can be a legitimate part of the system. Tia points out, “No one owns these things. Who owns a scale, for instance? Many professions use scales – nurses, doctors, nutritionists. They all weigh people, but no one owns the scale because they are all using it for a different reason.” The reason that identifies the practice of authentic occupational therapy is the tool’s relevance to patient occupation. This reason – the occupation – is created, in part, in the genres used to mediate occupational therapy practice. As a result, these genres not only guide practice by allowing personal histories and spaces to factor into treatment, but they also identify practice that looks like everyday occupation as occupational therapy. For instance, the therapist may use crochet needles as a treatment tool because this occupation is important to a particular patient. To an untrained casual observer, however, this therapy session may be misunderstood as a craft circle. Chris recalls bringing clients into a woodworking shop that she and her colleagues set up in a treatment facility. Therapy sessions there consisted, in large part, of working with clients to create projects like boxes – a set of activities that may have looked, to an outside observer, like a carpentry class. Below is an excerpt from treatment notes
taken by Ron that indicate the use of these kinds of commonplace tools.

Figure 7: Treatment Notes Excerpt (Ron)

These notes were taken during a treatment session with one of Ron’s home health clients. The notes indicate that the client’s activities include “doing dishes occasionally,” making coffee, and paying bills on the computer. Without the context of this treatment note, these activities could simply look like basic housekeeping, rather than the delivery of skilled medical care. Because the occupational therapy activity system is so inclusive, it is the genres associated with treatment that both draw anything into the occupational therapy activity system and explain the use of this wide range of objects in terms of occupational therapy practice. As a result, to some degree, practitioners write their profession into existence. I asked Tia about the importance of documentation to identify the use of commonplace objects as skilled occupational therapy. What follows is an excerpt of our exchange:

Stefanie: Okay, so if I’m coming in and I just watch, as an ignorant observer -- which I would be -- and I watch, you know, an OT work with that patient for half an hour, or whatever, and I watch a carpenter the next day kind of working with the same thing, where do I see -- where do I find that difference?

Tia: You won’t -- you won’t be able to see it. The only way to find it would be to find out what their goals are that they’re working on by looking at their charts or asking the patient why they’re doing what they’re doing, or asking the therapist. So, you would actually have to have either some sort of communication verbally or read what was
written. And, the OT should have in their writing, problem lists from the patient [for instance]: “I can’t prepare my own meals. My son has to come over three times a week.” And then [the OT will] break it down in his paperwork to say why can’t he – is it balance, coordination? Is it endurance? What are the issues that [the patient] can’t mobilize, and then he’ll have a long-term goal, and his long-term goal will *not* be, you know, “stand up” or, “mobilize.” His long-term goal will say, “Independent preparation of a meal in a kitchen with minimal supervision.”

As I explain in the next chapter, however, this reliance upon discipline-specific treatment notes and assessment genres to identify and describe the work of occupational therapists results in a somewhat precarious existence, because these genres do not often travel outside of the profession. As occupational therapy comes into contact with larger, more powerful activity systems, such as insurance billing, these original genres that pay such careful attention to the whole life of a person get translated and narrowed until the professional identity that the original documentation inscribes becomes lost in translation. Further, such translation has material consequences for the practice of occupational therapy. As new genres mediate activities differently, the profession’s vision narrows and, as a result, practice itself begins to change.
CHAPTER THREE: LOST IN TRANSLATION

In chapter two I argued that the genres used by occupational therapists reflect the profession’s careful attention to the whole life of a patient. These genres are built around an understanding of a patient’s occupation as the object of the profession’s activity system. This object invites an expansive professional vision that includes the patient’s life and history outside of a diagnosis. As a result, the tools used by a practitioner are often adopted from a patient’s activity system. The two systems share objects and tools in a way that strengthens the practice and identity of each. However, not all interactions with other activity systems honor the profession’s identity in this way. Occupational therapists must also interact with third-party billing systems, such as Medicare, in order to receive payment for much of their work. The genres that occupational therapists are required to use in order to mediate interaction with these activity systems conflict with the objects central to occupational therapy practice. In this chapter, I argue that the translation occupational therapists make from their own genres to the genres of activity systems with which they are in tension has a significant impact on the identity of the profession and, by extension, material consequences for the profession in practice.

Genre and Professional Identity

Learning to use a profession-specific genre is, in part, learning to be a particular type of professional. Many writing and rhetoric scholars have identified the work that genres do to professionalize and socialize novice participants in the health professions. For instance, in discussing the use of case presentations in medical school, Schryer and her colleagues write, “By using tools, human agents internalize the values, practices, and beliefs associated with their
social worlds” (“Structure” 28). As a newcomer learns to use the genres relevant to the work of her discipline, Schryer suggests, a new professional’s identity will be more strongly aligned with the objects at the center of the discipline. As a new occupational therapist, for instance, repeatedly uses genres that call for a patient’s occupation to guide treatment goals, the therapist will come to see occupation more clearly as the object of her work.

The role that genres play in enculturation speaks not only to the importance of genres in shaping professional identity, but also to the malleability of identity more generally. Amy Burgess and Roz Ivanic define “identity” in a way that reflects this flexibility:

When we use the term ‘identity,’ we mean something that is not unitary or fixed but has multiple facets; is subject to tensions and contradictions; and is in a constant state of flux, varying from one time and one space to another. This multifaceted identity is constructed in the interaction between a person, others, and their sociocultural contexts (Burgess and Ivanic 232).

This suggests that while an individual’s identity will be shaped by those disciplinary tools that she uses most frequently, these profession-specific interactions will not inoculate her from the values and beliefs of other systems. In her study of gender and social identity, Sigrid Norris suggests, “An individual’s identity is claimed, contested, and re-constructed in interaction and in relation to other participants” (183). This interaction can, in some cases, actually work to strengthen the values of one’s own discipline. For instance, as I argued in chapter two, the identity at the core of the occupational therapy activity system relies upon the therapist’s ability to adopt the objects of a patient’s activity system as her own. However, not all systems are congruent in this way. Individuals often must interact with activity systems that present some contradiction to their own. Different systems employ different tools toward the achievement of different objects, and such objects can be in tension. Citing Russell, Bawarshi and Reiff note:
While the inter-relations between activity systems enable individuals to perform and navigate complex social activities and relations over time and space, they also, as Russell describes, create conflicts and contradictions as individuals ‘are pulled between the object/motives of the multiple activity systems with which they interact’ (101).

Many scholars have noted the impact that these conflicts can have on professional identity, particularly when practice in one discipline requires the use of genres that are the property of another. Elizabeth Wardle’s observation of Alan, a computer support specialist learning to write in a university humanities department, explores this very challenge. In order to accomplish his work as a computer specialist, Alan must adopt genres generated and controlled by an activity system that is different from his own. Wardle notes that the resulting conflicts stem, in part, from the fact that Alan views himself as the expert subject of a computer science system, an identity he attempts to maintain outside of his own discipline. However, the humanities professors with whom Alan works view him as an artifact, or “a ‘tool’ to fix things” in their own system (7).

These contradictory positions or identities are contested, in part, through Alan’s use and misuse of genres specific to the humanities department.

The work of Bawarshi, among others, suggests that the contradictory identities Wardle observes can potentially be held in tension – even exchanged like identification badges as a person moves from system to system. Bawarshi notes, “We assume different rhetorical identities and perform different social activities as we negotiate our way from one environment to the next, often balancing multiple identities and activities at the same time” (71). This imagery of juggling or moving between identities implies, to some degree, that the identities being traded or balanced remain somewhat intact. An individual may be forced to set aside an identity that she occupies in one activity system as she steps into a contradictory system. However, in this paradigm, she may
also, presumably, switch back once she exits the conflicting context. Of course, this is not always the case. As Wardle puts it, “identities that are at odds with the values of other communities” have an impact on one’s ability to return to those original values (4). Moje et al. suggest, “At times, these sides or compartments may overlap and layers begin to congeal across identity compartments, thus producing hybrid identities” (431). Adopting a new identity reconfigures old ones, particularly where participation in a contradictory system is not the participant’s choice.

Occupational therapists must regularly participate in contradictory systems. In particular, they must use third-party billing systems and the genres developed in these systems in order to receive reimbursement for their work. The constraints of more powerful third-party billing genres warp the professional identity of the therapists who use them in ways that, ultimately, have a material effect on the practice of occupational therapy, even within the therapists’ own system. Goodwin warns that there are “ethical problems that can arise when we put our professional skills at the service of another profession, thereby amplifying its voice and the power it can exert on those who become the objects of its scrutiny” (626).

Identity Crisis

Occupational therapy is nearly one hundred years old as a profession. And, though it was born as a discipline from influences in psychology, social work, and medicine, for the first four decades of its existence, occupational therapy operated, if not in isolation from other healthcare professions, then certainly in contrast to them. This is apparent in the literature associated with the profession. For instance, an excerpt from the table of contents for an “Occupation Therapy”
book published in the early 20th century outlines some of the primary treatment tools that have come to be associated with the work of occupational therapy.

Figure 8: Excerpt from *Occupation Therapy*

These tools, which are derived from practitioners’ engagement with patient occupations, are perhaps surprising as topics in a healthcare treatment manual. However, tools like these, with the addition of modern technology such as cars and computers, continue to be central to the authentic practice of occupational therapy. The apparent simplicity of these tools has also created an identity crisis for occupational therapists concerned about the viability of their practice, particularly as a health science. From the earliest Slagle lectures, occupational therapists began to express this concern. In 1961, Mary Reilly said,

> The question I would like to speak to is one which each one of us has asked at some time or other in our professional lives...I am referring to an anxiety about our value as a service to sick people...The anxiety begins in a primitive form when we stand before our first patient and sense the enormous demands that a treatment problem makes upon the occupational therapy brush, hammer or needle. The wide and gaping chasm which exists between the complexity of illness and the commonplaceness of our treatment tools is, and always will be, both the pride and the anguish of our profession” (80).
In this lecture, Reilly notes the impact of conflicting activity systems upon her identity as an occupational therapist. She warns her colleagues against becoming too engaged in the medical activity system and, as a result, replacing occupation and whole person care with “sick people” and “illness” as the objects of their professional activity. Reilly reminds her listeners that medicine and occupational therapy operate as two, distinct systems that should, she suggests, be kept apart. She says:

There has been a First Principle postulated to explain the nature of man. We are told that the first duty of an organism is to be alive. Medical science derives its premise from this first law of life...The second duty of an organism is to grow and be productive. Occupational therapy ought to derive its premise from the second law of life (87).

In the mid-1960s, shortly after Reilly’s Slagle Lecture, Elizabeth Yerxa delivered a Lecture that was a direct response to emerging questions about the viability of the profession. Her address opened with a quote from the dean of the University College of Washington University, Dr. Earnest Brandenburg, who had declared – two years before Yerxa’s lecture – “It is my candid judgment that the field of occupational therapy in 1963 is not regarded and probably should not be identified as one of the professions” (127). Yerxa’s lecture is a rebuttal to Dr. Brandenburg. It is not simply a treatise on the ideal practice of occupational therapy, but an apologetic for occupational therapy as a profession. In making her case, Yerxa cites a new connection that the profession established during the two years between Brandenburg’s comment and the 1966 AOTA conference – a connection with Medicare. In 1965, President Johnson signed amendments to the Social Security Act that created Medicare and Medicaid. Yerxa writes,

Remember how we used to laugh, rather painfully, about the persons who would smile politely and say ‘oh isn’t that nice’ when we told them we were occupational therapists? For they had no idea of what we did...We still experience similar responses but they occur less and less. More significantly, the people and agencies who can recognize the
need for our services and can do something about it are well aware of how much they need us. The Medicare bill and corresponding state legislation recognize the need for occupational therapy in hospital, home health services and extended care programs. These bills and regulations write our profession into the law” (Yerxa 129, emphasis added).

In hindsight, the practitioners that I interviewed see this connection as necessary, but also as the beginning of a significant assault on the identity and practice of occupational therapy. However, from the vantage point of the mid-1960s, the ability to tap into the reimbursement power of a large, national insurance provider seemed a welcome answer to anxiety over the legitimacy of occupational therapy as a healthcare profession. A decade before Yerxa delivered her keynote address, the 1956 Slagle Lecture opened with the admission that, “All of us have heard and perhaps uttered the cry of frailty: occupational therapy will not live to see another decade” (Sokolov 19). Tethering the practice of occupational therapy to the Medicare reimbursement system seemed to stabilize and legitimize the identity of a profession on the edge of extinction. However, Tia describes this connection in a way that begins to hint at current practitioners’ cynicism about the reasons for, and usefulness of, such an attachment:

In the sixties when Medicare started, people thought, “Let’s jump on board with the AMA. We’ll be like the American Medical Association, because they’re getting paid every time somebody walks in their door,” and we totally shifted our focus...Before the sixties...it was almost always, you know, looms and, because it was time specific it was what was popular in the fifties and the sixties –more like ceramics and macramé and leather work and carpentry...[It was] having you create something purposeful...Then Medicare hit and we started saying “we want a piece of the pie.”

As this chapter will outline, Medicare and other third-party payers operate on a set of values and beliefs that are distinctly different from those that inform the occupational therapy activity system. Aligning with a conflicting system continues to have a significant impact on
occupational therapy identity and practice, and this impact can be observed, in part, through the language and genres that mediate communication between systems.

Borrowed Language

Communicating with billing systems is not only a matter of understanding different genres, but also a matter of learning to speak a different language. For instance, Medicare, the largest third-party payer for healthcare in the United States, trades largely in numbers – more specifically, five-digit codes. Medicare employees read these codes as reimbursable activities. In order to arrive at these five-digit codes, treatment notes must be translated into “Current Procedural Terminology (CPT)” (one or two-word phrases), that are created and copyrighted by the American Medical Association (AMA). The AMA website indicates:

The AMA is your trusted source for official Current Procedural Terminology (CPT®)—the most widely accepted medical nomenclature used to report medical procedures and services under public and private health insurance programs. Anyone who bills a health insurance company should have a CPT and ICD-9 codebook in their office.

The site also identifies the people involved in the CPT editorial panel – a group of physicians and representatives from insurance companies. The relevant list is included below.

Figure 9: CPT Editorial Panel Members
No occupational therapists are listed as participants in this panel, and the terminology that this panel creates requires a significant reduction of the original treatment notes recorded in occupational therapy forms – genres that tend toward narrative writing. Additionally, there is no language or code for leisure activities (such as needlework and gardening) because they are not recognized or reimbursed by Medicare. These tools, central to occupational therapy’s unique identity, are excluded from reimbursement because they are not “medically necessary.” In the interview excerpt below, Tia discusses a potential approach to treatment for a patient to improve strength after a stroke. Tia describes taking a patient, who loves basketball, out to the court to work on strength and hand-eye coordination by shooting free throws. When insurance is billed for this session, however, the identity of both the patient and the occupational therapist become hidden in translation. Tia explains:

I have to translate because if I’m having somebody take a basketball and use their non-dominant hand to toss it up in a net to work on hand-eye coordination after a stroke, Medicare wouldn’t reimburse for that because they don’t understand that. So, in my notes I have to play the game about not making it look like we were playing a game. There’s that dichotomy of “I’m playing basketball, but for the insurance company I did not play basketball. I was doing an ipsilateral motoric control overhead using, you know, a spherical grasp object.” With my students, I call them smart words. I’ll ask, “What did you do with your patient?” And they’ll say, “Well...I would take the kid and I would roll out some play dough,” and I’ll say, “Now, put it in smart words. What are smart words?” And then they’ll say, “Okay. I had the child do a bilateral, you know, dual control motoric activity,” and they’ll throw out the smart words that are really more physiological and medical model words so that Medicare or Medicaid will say, “Okay – that was medically necessary.”

Such translations align more closely with Current Procedural Terminology, which is ultimately converted into corresponding billing codes – five-digit numbers. As a result, the actual work of the occupational therapist is almost completely obscured. Additionally, the indication that the original language used to describe occupational therapy practice must be translated into “smart
words” reflects some of the anxiety about professional identity that precipitates the need for these translations.

**Conflicting Genres**

The translation into Medicare billing codes is the final step in a series of genres that transform original patient-therapist activity into increasingly bite-sized, bounded genres. The documents that follow here trace one such series of translations from the original occupational therapy treatment notes (exhibiting a highly individualized approach to genre creation and use) to the final reimbursable, five-digit code. The series begins with notes from one of Ron’s patients – an investment banker who made a living by quickly identifying pertinent information from complicated spreadsheets and related financial genres. The patient then had a stroke resulting in the loss of his ability to scan. This is not a loss of vision, but rather a cognitive impairment that prevents patients from identifying the left “edge” of the available field of vision. This patient, for whom numbers were a primary occupation, could not determine where a number, or set of numbers, began. Below is an excerpt from Ron’s treatment notes.

![Figure 10: Original Treatment Notes (Ron)](image-url)

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These notes outline the patient’s frustration with his limitations and provide, in narrative format, a sense of the data that Ron believes “counts” toward the establishment of the client’s diagnosis and treatment plan. Ron writes, for instance, “Patient telling stories about hospital events which seem delusional. Reports ‘strange events’ involving catheter and sheet.”

The narrative notes are supplemented by a cognitive assessment that Ron developed specifically for this patient. Because the patient’s work, prior to the stroke, involved proficiency with reading spreadsheets, Ron devised a simple spreadsheet that outlines fees for fitness services (below).

![Fitness Training Fees Table](image)

Figure 11: Customized Cognitive Assessment Table (Ron)

Ron then asked the patient to complete an accompanying worksheet with simple questions that required the patient to be able to read and understand data from the spreadsheet. The worksheet is included below.
This individualized approach to evaluation, tapping into the patient’s occupation and using genres created by Ron specifically for this patient, is a reflection of occupational therapy’s belief that the whole life of a person should factor into treatment. However, these evaluation genres stand in contrast to other, standardized cognitive assessments developed by practitioners from other, related professions. For instance, the assessment included below, called the “Short Orientation Memory Concentration Test,” was initially developed by psychiatrists for use in their field, but it has since been employed by multiple health professions as a standardized assessment of cognitive ability. The form is widely used in rehabilitation centers and skilled nursing facilities. The questions are the same for every patient, regardless of interests, experiences, or occupations. The patient is given points for every error made during the assessment. The note at
the bottom of the assessment indicates, “Any error score of 0-6 is within normal limits.” Ron completed the copy included here.

![Short Orientation-Memory-Concentration Test](image)

Figure 13: Standardized Cognitive Assessment (Psychiatry)

Yet one step further removed from the patient is the document included below. This paperwork is completed at regular intervals by employees in the billing department at rehabilitation and long-term care facilities as part of the Medicare reimbursement process. This
nearly 40-page document is rather ironically called the “Minimum Data Set,” and it records information from all practitioners who interact with a single patient. Reproduced here is a section from the pages in this document that addresses “mental status.”

![Staff Assessment for Mental Status](image)

Figure 14: Minimum Data Set – Mental Status Section

The numbers entered in the boxes in the left margin of this document are part of a formulaic calculation, the result of which determines how much therapy (and other services) insurers will reimburse. Not only are the options here limited, and reflective only of the patient’s “appearance,” but the patient is also assessed based upon information that would likely be somewhat difficult to remember, even for someone with excellent recall ability (room location and staff names in a setting other than one’s home). While Ron’s initial assessment of his patient’s cognitive ability was personalized - geared toward the patient’s occupation prior to
illness – these questions are entirely focused on the patient in a very limited chronotope, as a resident in an unfamiliar healthcare setting. The results of these standard questions are translated into numbers and checks inputted into a series of boxes by someone who likely has very little direct interaction with the patient and no training in the work of the disciplines reflected here.

Ultimately, the exchange between the patient and the occupational therapist is transmitted to Medicare as a single, five-digit number. “97535 – that is the code for self-care and community management” Ron explains, “and that code covers ninety-five percent of what I do.” At the level of the Federal government – the largest single third-party payer for occupational therapy treatment – everything the therapist does during a session can be represented this way: 97535. When Ron was in private practice, he was directly responsible for completing and submitting paperwork for billing to Medicare. He explained, “You submit the billing electronically, and magically, two weeks later you get a deposit in your account.”

In her book The Rhetoric of Economics, economist Deirdre McCloskey writes, “Do numbers tell? According to the official rhetoric, yes: only numbers. Most [people] believe that once you have reduced a question to numbers you have taken it out of human hands” (McCloskey 100). Goodwin echoes this observation that translation into numbers eliminates practitioners, writing, “The definitiveness provided by a coding scheme typically erases from subsequent documentation any cognitive and perceptual uncertainties...as well as the work practices within which they are embedded” (6). In his essay “Walking in the City” Michel de Certeau notes the ways in which distance – in this case the distance between practice and reimbursement – can result in the professional erasure that Goodwin identifies. De Certeau
stands on the top of a New York City skyscraper and reflects upon the view of the city afforded him from this height, writing, “The panorama-city is a ‘theoretical’ (that is, visual) simulacrum, in short a picture, whose condition of possibility is an oblivion and a misunderstanding of practices” (158). The further a person, or a genre, gets from an activity, the less the resulting picture can actually be identified as the original. It becomes, de Certeau suggests, something else. The danger, he argues, is not in creating a different perspective or genre or practice, but in mistaking it for the original. Likewise, the further language and genres travel, both in terms of values and geography, from the original practice of occupational therapy, the greater the danger of mistaking the resulting translation for the original. When I reviewed a draft of this chapter with Tia, talking over the translation of narrative treatment notes to a five-digit code, she said, “Trying to understand occupational therapy from the perspective of codes is like trying to critique a novel based upon Cliff’s Notes. It’s not the original.”

Conflicting Genres Create Conflicting Practices

Using third-party payer genres obscures the identity of occupational therapy, but the occupational therapist, like practitioneres in so many other professions, must negotiate the demands of such conflicting systems in order to be reimbursed for much of her work. It is easy to assume that once the therapist returns to her own system, her own tools, and her own genres, practice remains untouched and purely occupation-focused. The translations outlined here, then, might be construed as a simple misunderstanding. Perhaps Medicare doesn’t understand occupational therapy. However, in theory, such a misunderstanding does not affect what the occupational therapists do.
In fact, this is not the case. The use of genres that are not generated out of the profession’s core values mediates practice that also does not remain true to an identity rooted in the patient’s whole life. Glen Gillen, who delivered one of the most recent Slagle Lectures, noted, “We feel that the tools of our trade are both commonplace and unsophisticated. However, our adoption of and substitution of, other professions’ approaches and techniques” has resulted in “professional role blurring and loss of professional identity” (642). Gillen argues that the profession is, to a certain degree, being colonized by the values and beliefs of the systems that control the right to work in healthcare. The use of a genre actually “produces the self” as Moje, Luke, Davies, and Street indicated, and the translation of occupational therapy language and genres to the language and genres of third-party payers works to produce a new self. Professions are written on each other through the forms that they use as tools, and the result is something that neither one may wholly recognize.

What is at stake in the translations made necessary by the conflict in activity systems noted here is not simply a perception of what occupational therapy means and does, but the process of translating genres ultimately becomes a translation of practice. Chris remembers one example of this translation that occurred while she was working at a skilled nursing facility. She recalled:

An example is reimbursing well for groups. So, if you had a group of four people and you treat them for an hour, you could actually [at one time] bill each one of those for an hour...so, not only did your productivity go up, but you maximize your reimbursement. And so, we were actually told, or dictated, to do a certain number of groups per calendar week. [Administrators would say], “We want groups, groups, groups – groups are great for patients. Patients love groups, and it is good for them.” Well, there’s a kernel of truth in that. Yes, groups are great in certain settings – you know, peers can help each other. There are good things about group treatment. It’s not all bad or all good...But the funny
thing is, about a year later, or two years later, Medicare changed its rules about groups. And so, if you had a group, it could only be a group of four – it couldn’t be more (because sometimes groups were big) – and you could only charge 15 minutes per person for an hour with the group. So, there goes your reimbursement, and so, all of a sudden, [the same administrators said], “Groups aren’t important. Patients don’t like groups. Don’t do groups.” So what changed? Did the patients change? Did the therapists change? No – reimbursement changed.

This is not a simple misunderstanding. Chris notes a change in practice based on the requirements of the third-party payer. When I reviewed a draft of this chapter with Ron, he went to his desk and pulled out two sets of evaluation forms utilized in the HOPE Clinic, a free occupational therapy clinic that he and Tia started at the university. This clinic is entirely unconstrained by the requirements of third-party payers. Because the treatment is free, and volunteer therapists staff the clinic, those who work in this setting have no need to translate their work. The first figure here is the original evaluation form, used at the clinic’s inception.

![Figure 15: Original HOPE Clinic Evaluation Form](image-url)
This form is made, essentially, of open spaces, reminiscent of Ron’s notes about the investment banker that were recorded on simple lined paper. However, over time, a therapist who worked in the HOPE clinic altered the form. The current form, now a two-page document, is reproduced below.

![Current HOPE Clinic Evaluation Form](image)

Figure 16: Current HOPE Clinic Evaluation Form – Page 1
These evaluation forms are potential examples of how the repeated act of translating in other settings impacts practice, even in a setting where no translation is required and a pure vision of occupational therapy work can be enacted. For instance, while there are lists of potential treatment options included in the second evaluation form, leisure activities are absent, and there is a focus on upper body (UB) range of motion – both changes to this evaluation genre that seem to reflect that kinds of preferences and practices that originate in other activity systems.

Additionally, the table on the first page of this new form might be read as a written representation of the identity confusion resulting from repeated interaction with conflicting activity systems. The table is an amalgamation of elements from both the Canadian Occupational
Performance Measure (COPM) created by occupational therapists (discussed here in chapter two), along with the kinds of upper body measures that dominate evaluation forms created by hospitals. Ron offered these changes as an example of the ways in which repeated translation eventually alters even the most protected, or isolated, system of practice.

Occupational therapists recognize the challenges to their identity that are created as they translate their work. Tia said, “We worry about our identity a lot. We talk about it a lot.” Unless a therapist works in a setting like the HOPE Clinic (which is the only one of its kind in the state) then interaction with third-party payer activity systems is unavoidable. How, then, do occupational therapists write to maintain their unique identity while still operating in communication with conflicting activity systems? The next chapter explores two attempts – one by the AOTA and one by an individual therapist – to establish genres that can work across these boundaries without compromising the identity of participating practitioners.
CHAPTER FOUR: WRITING BACK TO CONFLICTING COMMUNITIES OF PRACTICE

In chapter two, I argued that the genres used by occupational therapists reflect the attention they pay to the whole lives of their patients. This is accomplished, in large part, by foregrounding occupation as the object of the occupational therapy activity system. In chapter three, I argued that the genres of conflicting activity systems also shape the identities and practices of the therapists who use them. The genres that mediate activity in third-party payer activity systems, particularly Medicare, require a reductionist translation of occupational therapy genres into almost unrecognizable five-digit numbers, or billing codes. This translation distorts outsiders’ perceptions of occupational therapy, changes therapists’ view of themselves and, ultimately, impacts practice. In this chapter I explore the work that occupational therapists are doing to try to maintain the core values of the profession even as they participate in conflicting activity systems. I employ Wenger’s concept of brokering to examine two different attempts to write back to the powerful systems that act upon occupational therapy, and I argue that the most successful brokers mirror, in their brokering work, the highly individualized approach that occupational therapists take to treatment. In doing so, these approaches position the therapist as the expert in the brokering exchange.

**Conflicting Activity Systems**

Wenger’s discussion of brokering across communities of practice includes acknowledgment that negotiation between sometimes conflicting communities is necessary to accomplish almost any work. Further, this negotiation, or brokering work, is made easier when
the person doing the negotiating occupies a position of authority in both communities. However, not every negotiator is afforded such a position. More often, an individual must negotiate with at least one community in which she has no authority. The key, in these situations, is how the broker maintains her own identity. Moje et al. suggest, “Identities are produced in and through not only activity and movement in and across spaces but also in the ways people are cast in or called to particular positions in interaction, time, and spaces and how they take up or resist those positions” (430 emphasis added). Malea Powell describes this work of resistance as an act of “writing back.” She recounts entering the Saint Louis University Law Library to review the library’s Native American Reference Collection. She writes, “I returned to the library each day to be excavated by the words of people who believed that me, and mine, were worthless...savages...lazy...violent...I returned because I was learning how much those words mattered, still matter” (118). Powell’s piece then includes a poem that she describes as her “first attempt at writing back to that archive.” The Poem has two parts: “Part One – how they did it” and “Part Two – how we undo it.” If you feel written on,” Powell says, “write back” (118).

Of course, the work of writing back to the deeply entrenched, broadly destructive, and stubbornly etched history of colonization and genocide that is the subject of Powell’s narrative is an eminently more challenging project than the call for a long-established profession to write back to the government’s positioning of its identity. However, Powell’s challenge seems a relevant one, even if applied here on a much smaller scale. Medicare, for instance, which ultimately reduces the patient-caregiver interaction to a five-digit number that is submitted in exchange for payment, seems a system to which someone should write back. Interaction with
third-party payers is necessary for most occupational therapists to make a living, but these systems often do not recognize the patient’s life, the therapist’s values, or give the therapist agency to assert those values outside of her own system. Powell warns that such systems are not easy to penetrate. She writes, of her work in archives, “Access required knowledge of a very specialized type...how to fill out forms, pay for things, use the physical space – all of these an elaborate maze each time I visited someplace new” (116-117). This image of an elaborate maze is appropriate for understanding the third-party payer activity system. Access to this system is limited, if not impossible. Included below is a flowchart that explains the steps to request changes to the “National Coverage,” which outlines what services are reimbursable by Medicare.

Figure 18: National Coverage Flow Chart
This condensed flowchart represents a nine-month process that, like the classic board game *Chutes and Ladders*, appears to conclude with the potential for a loop back to the beginning “Preliminary Discussions” phase. The chart is accompanied by a narrative that warns:

We encourage, but do not require, potential requesters to communicate, via conference call or meeting, with our staff in the Coverage and Analysis Group (CAG) within the Center for Clinical Standards and Quality (CCSQ) before submission of a formal request...A significant proportion of potential requesters have either withdrawn or substantially amended their initial requests after formal discussions with us.

To further complicate this process, the services that are approved for inclusion in the National Coverage are represented by specific procedural language and billing codes, established and maintained by the American Medical Association (discussed in chapter three). A similarly complex flowchart represents the path for requesting changes to current procedural terminology and related coding. The American Medical Association indicates, “Requests for code changes or revaluation must be reviewed by the New Technology Pathway.” This Pathway is represented by the following flow chart.

![New Technology Pathway Flow Chart](image)

Figure 19: New Technology Pathway Flow Chart (AMA)
Any individual healthcare provider who wishes to change the landscape of reimbursable care must traverse this labyrinth of paperwork, review, and discussion. It is no wonder, then, that occupational therapists more frequently choose to translate their work in order to fit into existing boxes, even if this translation obscures professional identity. The process outlined to make one’s profession more visible seems, as Powell writes, “designed to keep the knowledge safe, protected, away from the prying eyes of the uninitiated and uniformed” (117). How then, as Powell asks, is it possible to “sustain ‘our story’ in the face of ‘their story’” (123)?

Powell’s question points to a complication that activity theorist Engeström identified as a double bind. In these situations, Engeström observed that an individual is forced to take up a position in an activity system, but that same system gives her no agency to resist or affect change. Further, in the case of particularly entrenched or powerful conflicting systems, Engeström suggests that an individual cannot resolve the resulting conflicts alone. Citing Engeström, Wardle argues,

What activity theory calls re-mediation (resolving systemic contradictions) requires more than individual innovation. Individuals cannot re-mediate the contradictions in the activity system by themselves because the contradictions are in social/material relations among groups of people and the tools they use. Thus, contradictions must be resolved by groups of people (online).

This seems true for occupational therapists participating in a profession that is largely misunderstood, both by the general public and the third-party payers who reimburse their work. The re-mediation that Engeström calls for is made difficult not only because the third-party payer system with which occupational therapists must communicate is complex, but also because occupational therapists occupy few positions of authority in such insurance systems. The most
obvious potential group of people, therefore, to establish connections between occupational therapy and third-party payers appears to be the profession’s national organization.

The AOTA as Group Broker

Established in 1917, the American Occupational Therapy Association, Inc. (AOTA) pursues its mission to “advance the quality, availability, use, and support of occupational therapy through standard-setting, advocacy, education, and research on behalf of its [more than 50,000] members and the public” (aota.org). This organization seems the kind of group capable of resolving the double bind that individual therapists face while interacting with large insurance systems. And, there is certainly evidence that the organization expends significant energy and resources on attempting this kind of brokering work.

The AOTA’s annual report includes a section entitled “Articulating Our Value,” designed to address a perceived lack of understanding about, and reimbursement for, the profession. The activities catalogued in this section may be read as an attempt by the national organization to write back to the government. The report recounts an ongoing advocacy campaign to repeal the therapy cap in Medicare (essentially, a removal of the limit on allowable total reimbursement for therapy), including the attendance of 750 AOTA members at the “Annual Hill Day” in Washington, DC. While some of these campaigns have achieved the desired change, the effectiveness of these direct-advocacy efforts, more broadly, appears to be debatable. For instance, the 2014 annual report lists the following as an accomplishment:

AOTA staff and volunteers continue to work with the American Medical Association and other health care professional associations to advocate for new and revised billing codes to better meet the needs of occupational therapy practitioners (online, emphasis added).
If the AOTA is a group focused upon building connections across conflicting activity systems, these connections have not yet, at least in several cases, yielded a significant change in practice.

While the AOTA advocacy efforts do, over time, lead to practical changes in the billing codes and related practices, several of the occupational therapists that I interviewed expressed some frustration at what might be understood as ineffectual brokering, to use Wenger’s terms. For instance, Chris was a therapies manager at a skilled nursing facility. She explained, “[in these settings], productivity standards could be 95, even 98% of billable hours. So, that means when you come in to work, all your time needs to be devoted to billing for patients.” This is particularly difficult when documentation, talk between caregivers, interaction with patients that is not considered “medically necessary,” lunch, and any evaluation taking longer than 15 minutes are not billable. All of these activities, in a 98% productive environment, must be accomplished within a total of 48 minutes across a 40-hour workweek. All of the occupational therapists participating in this study identified productivity standards, which are built in response to Medicare billing structures, as a significant barrier to optimal practice. When I asked Chris what the AOTA involvement has been in addressing this problem, she replied:

I was always hoping the AOTA would – you know, [I wondered], “Do you guys know about this? Would you do something about it?” And, finally last year – it just came out a couple months ago – there was a paper, if you will, a statement between AOTA, PT, and Speech on productivity. And, it didn’t really…it said – it was kind of soft and flowery, but pretty much it did say that, you know, “Don’t do anything that violates your license.”

Direct advocacy and legislative efforts seem doomed to failure without also addressing the perhaps more fundamental concern – that occupational therapy is not nearly as widely understood as other health professions and, perhaps as a result, cannot effectively forward its values for inclusion in legislation. This concern is reflected in the fact that the majority of the
accomplishments listed in the most recent “Articulating Our Value” section of the AOTA annual report are marketing efforts – specifically efforts to clarify the work of occupational therapists. The most substantial of these efforts, at the time of this writing, is a campaign built around the slogan “Living Life to Its Fullest.” The AOTA suggests,

The purpose of these materials is to focus on promoting occupational therapy...All too often we find it difficult to explain what OT is succinctly. We may hear explanations like ‘it’s like PT but more holistic’ or ‘OTs help you with bathing and dressing,’ but we all know OT is so much more than that! ...We invite you to review the following discussion questions with your colleagues, friends, and family.

The AOTA provides members with a “Brand Toolbox” on its website, which includes items like a one-page “Q & A” sheet and a “Wallet Guide,” excerpted below:

![Image of Wallet Guide](image)

Figure 20: Wallet Guide (AOTA)

The clock with fourteen hours, included in the far left panel of the Wallet Guide, is meant to signify life “to its fullest,” and the text provides short dialogue for practitioners to explain, “just what occupational therapy is about.”
This creation of a “one-size-fits-all” communication tool, intended for use by all practitioners in conversation with all audiences, seems to run counter to the actual practice of occupational therapy, which focuses so heavily on individualized approaches to treatment. Other efforts by the AOTA also seem somewhat out of line with the profession’s ethos in practice. For instance, at the time of this writing, the AOTA has developed a “Centennial Vision” in recognition of the approach of the profession’s one-hundredth birthday in 2017. The Vision is articulated as follows:

We envision that occupational therapy is a powerful, widely recognized, science driven, and evidence-based profession with a globally connected and diverse workforce meeting society’s occupational needs.

Tia, who holds membership on several AOTA committees, told me that recent meetings to develop the vision for the next one hundred years have inspired lengthy conversations about the current Centennial Vision. “We talked a lot about the word ‘powerful,’” Tia told me. “Is that really what we want? To be powerful? I suggested ‘essential’. I want to be an essential part of someone’s care.” The use of language like “powerful” also seems at odds with the profession’s values, as expressed through practices like sharing significant agency with patients.

Perhaps most problematic is the fact that efforts like the “Brand Toolbox” and genres like the Wallet Guide position their users as novices in need of assistance in the basic explanation of their work. While reviewing a draft of this chapter with Ron, I asked him about the wallet guide – a tool that he was not aware of and that he indicated he would be unlikely to use. “I’ve been a therapist for twenty years now. We have bigger problems if I need a wallet guide to tell someone what I do.” Unfortunately, despite the considerable energy marshaled by the AOTA in creating the artifacts that make up the “Living Life to Its Fullest” toolbox, not one of the occupational
therapists that I interviewed produced a wallet guide when I asked them to tell me about their profession. In fact, my mention of it produced some eye rolling. It appears that at least some of the AOTA efforts to negotiate boundaries between occupational therapy and other, often conflicting communities of practice have become what Wenger refers to as “completely self-involved” processes that “fail to create connections to anything beyond themselves” (115).

Wenger suggested that a successful broker should have legitimacy and influence on both sides of the boundary she is attempting to cross. And, certainly one could make the argument that despite its size, the AOTA does not have nearly the legitimacy with the Federal Government as, for instance, the American Medical Association. As Ron noted, “We do sit at the table, but we do not have the clout and the recognition.” However, Tia and Ron’s comments highlight perhaps a more pressing problem – that the national organization may not actually have legitimacy and influence within its own discipline. Each of the therapists that I interviewed expressed, in a range of terms, their own skepticism about the relevance of the AOTA to daily practice. At best, the organization’s “Living Life” campaign expends significant energy and capital to cast a wide net of conversation in the hopes that an occupational therapist and a Medicare staff member will get caught together at some point in a crucial conversation about a wallet guide. At worst, the campaign imposes a potentially insulting novice identity on its own members. Further, because the wallet guide is not grounded in practice, its language is somewhat unfamiliar, even to the occupational therapists expected to use it as a tool to describe their work. In fact, the wallet guide includes language explaining that it has been prepared “to help you spread the meaning of that phrase [Living Life to Its Fullest] and an understanding of our profession.” Rather than
functioning as a bridge between communities, the branding campaign itself creates a new object – inserts additional space – between the boundaries of practice most in need of an introduction.

Successful Individual Brokering

The AOTA branding campaign may be an example of an ineffective collection of boundary objects, which Wenger defined as “artifacts, documents, terms, concepts, and other forms of reification around which communities of practice can organize their interconnections” (Wenger, 105). However, if used appropriately, these boundary objects may be the key to working across conflicting communities. Long before the AOTA unveiled its “Living Life to Its Fullest” toolbox, Vicki was acting as a boundary broker, creating genres used to write back, directly, to Medicare. Vicki has significant experience writing successful appeal letters to combat Medicare reimbursement denials – a skill she teaches to other practitioners. She remembers when she first understood how to write this genre:

So, it’s the early 90s. I’m a new grad. I had just started working, and we started getting denials [from insurance]...Medicare didn’t understand – there was a lot of educating that therapy had to do through documentation to educate the third party payers on why we were doing what we were doing.

The documentation that Vicki references here includes appeal letters that are generally written to certified professional compliance officers who work for Medicare at the local level. Often, such compliance officers have little or no training in the fields for which they are reviewing claims. In fact, posted advertisements for job openings in this role indicate, “There is no experience requirement...two years experience working with compliance programs is recommended.” Vicki says,
I’ve never known a therapist [who was a compliance officer]. It would be very rare for it to be a therapist, which is crazy. Sometimes people who really don’t have much of an education in these areas are just given a thing to look at to see what to check off – what they’re looking for and, if it’s not there – ‘deny’. And that’s when I break out my SHAZAAM!

“Shazaam” is the word Vicki uses to refer to phrases that she used repeatedly in writing appeal letters. Vicki began working as an occupational therapist just after the Omnibus Budget Reconciliation Act (OBRA) of 1987 went into effect. This act provided Medicare reimbursement for outpatient rehabilitation services, either for nursing home residents or those recovering from inpatient services, such as surgery. The key here was in educating those implementing the new law about the role occupational therapy, specifically, could play in achieving the goals outlined in OBRA: “To assist residents to attain and maintain the highest level of physical, mental, and psychosocial function possible in light of each resident’s individual, unique situation.” Vicki explains,

So, one thing we really had to document was, ‘What is the medical necessity? Why does this patient need skilled OT services vs. why can’t nursing do it, or a nursing assistant, or activities, or the monkey on the corner of the street?’

In order to achieve this goal, Vicki used the language of the new OBRA regulations in her appeal letters. She recalls, “[Some of this] was actually written by the Department of Health. I was like, ‘Well, this is what you said we’re supposed to do. This is what you said.’” Vicki combined occupational therapy practices and government language, remixing elements of both occupational therapy documentation and OBRA guidelines in her appeal letters. These phrases, with a very high degree of success, resulted in the reversal of reimbursement denials. One such phrase related to the engagement of occupational therapy in wheelchair positioning.
We had to start writing these appeal letters, because they didn’t understand the medical necessity of OT in wheelchair positioning. Why can’t maintenance just put a seatbelt on there? And so, I used this statement every time I wrote an appeal letter for wheelchair positioning. It talks about adaptive seating as a process. My favorite is: ‘An improperly fitted seating system is potentially as harmful and as hazardous as a self-prescribed drug. It can cause trauma, secondary deformities, disabilities, and other complications that may be irreversible.’ How do you deny it after I’ve said that? BAM! SHAZAAM!

Early in our conversations, Vicki shared a story with me that has, at first glance, nothing to do with these Medicare appeal letters, but it may offer important insight into the practices and qualities that made Vicki a successful boundary broker between her community of practice and the seemingly impenetrable maze that is Medicare. Vicki recalled working at a skilled nursing facility and being assigned to a particularly difficult patient, who she referred to as Mrs. Wilson. Mrs. Wilson had fallen in the facility, broken her hip, gone to the hospital, and come back for rehabilitation. When Vicki came into the room to introduce herself and help Mrs. Wilson to get out of bed and begin her therapy, Mrs. Wilson refused to go because the doctor had not given her in-person instructions to do so. Vicki continued:

So, I said, “No, really. There’s a [doctor’s] order, you know, to get out of bed.” [And Mrs. Wilson says,] “The doctor did not tell me how to get out of bed. I am not going to therapy. I am not getting out of bed.” Now, I could have just said, “Okay” and written an order: “Discharge from therapy. Patient refuses therapy,” but that would not have been the ethical thing to do. So, in her mind, the doctor’s a man. Well, the only man in the building was the maintenance man – cowboy boots, jeans, plaid shirt - plaid flannel shirt every day. So, I go get the maintenance man, and I’m like, “Can you help me out?” So, he would put on a lab coat, put a stethoscope around his neck, march into Mrs. Wilson’s room and say “Hi Mrs. Wilson. I’m Dr. So-And-So. It’s time to get out of bed and go to therapy.” And she’d go, “Okay!” And she’d get up and go to therapy! That’s a therapeutic fib...If she’d not come to therapy, she probably would have developed wounds. She probably would have lost her ability to ambulate and take care of herself.

This is an early story of Vicki’s approach to brokering transfer – an insight into her process for the creation of boundary objects. In the case of Mrs. Wilson, Vicki had an order to
deliver therapy, but the piece of paper, and the therapist, did not look convincing to the patient. Vicki understood that, to her specific audience, authority, trust, and respect looked like a white lab coat and a stethoscope. So, she blended materials at hand, and remixed the tools at her disposal into an effective boundary object. One could argue that she employed the same approach with the appeal letters, selecting vocabulary that looked familiar and, therefore, trustworthy to her audience – remixing the language at her disposal into an effective boundary object. Vicki has been an effective broker because of her use of such objects, despite her lack of official position or authority with the third-party payer community that she is trying to impact.

Lesley Bartlett and Dorothy Holland use the term “artifacts” to discuss a wide range of tools that a newcomer may use to mediate agency in an unfamiliar or even hostile habitus, or world. They observe, “People constantly produce artifacts that may become important in refiguring cultural worlds, giving flesh to new identities, and so eventually transforming habitus. Cultural artifacts are essential to the making and remaking of human actors” (13). In his book *Reassembling the Social*, Bruno Latour suggests that a unique actor (here, an individual practitioner) can even use established standardized forms in ways that transform them into new tools. Latour writes,

Especially important is that which allows actors to interpret the setting in which they are located...there is still a huge distance between the generic actors preformatted by those movements and the course of action carried out by fully involved individualized participants (205).

This is, to some degree, what Vicki does – she takes up the language of the laws that govern Medicare, and she alters this standardized tool to serve and reflect the identity and work of occupational therapy.
Perhaps Latour’s generic actor (for instance, the “Living Life to Its Fullest” campaign) is ultimately only effective when it is embodied in the lives of individual patients. This approach may work precisely because it is the value that occupational therapists forward more than any other – the importance of understanding treatment as a response to an individual’s circumstances, preferences, and goals. Sigrid Norris and Rodney Jones argue, “The most pressing social problems in the world must be understood not as a matter of the dealings of large institutions (governments, corporations) and abstract ideas (justice, democracy) but, rather, as a matter of our individual actions within the semiotic aggregates that institutions and ideologies produce” (11). The problem of identity anxiety that plagues occupational therapy, particularly as the profession struggles to create space for itself in relationship to more powerful systems, can only meaningfully be addressed at the level of everyday literate activity – where one therapist works to restore the identity of one patient at a time.

Perhaps more importantly, the artifacts that Vicki creates position her as an expert educating her counterparts at Medicare about her profession. By contrast, the genres in the AOTA’s brand toolbox position users as people who themselves must be educated about the profession in which they have participated, in some cases, for decades. The efficacy of each of these genres seems closely tied to the position of the respective authors within the occupational therapy activity system. Where the author is also the user, the genre seems more effective. This is also true of assessment genres like the fitness fee spreadsheet (discussed in chapter three), which is both authored and used by Ron. Translation from one activity system to another is often inevitable (in this case to get treatment for patients and to get paid for that treatment). However,
the tools created for, and employed in, that translation can work to cast not only the patient, but also the practitioner as the expert advocate for her own identity.

From Individual Resistance to Systemic Change

While the most effective brokering work appears to be grounded in specific, local circumstances, it is possible for individual action to, ultimately, work its way into the national conversation. One example of this is in recent changes to the way that occupational therapists approach patients who have reached what healthcare professionals refer to as a plateau. These are often patients who have a degenerative illness (such as dementia) or who have sustained a severe stroke and, as a result, do not exhibit what many third-party payers refer to as “measurable improvement.” Despite the fact that reaching and sustaining a plateau – halting, in essence, a decline in health – would be remarkable for someone with a degenerative disease, occupational therapists have often received denials from Medicare for attempting to bill for services that “maintain” health or independence. Vicki remembers writing appeal letters to reverse such denials. She recites another “SHAZAAM”:

My first sentence with a degenerative disease is, I just say it: “Although this patient has a degenerative cognitive disease, they still have the ability to do this, this, this, and this. They still have the rehab potential to do this, this, this, and this, and this is why. And they need my services to do this.” BOOM! SHAZAAM!

The therapists that I interviewed indicated that obtaining reimbursement for patients with degenerative diseases was nearly impossible until approximately two years ago, when a federal judge ruled, “Medicare beneficiaries can no longer be denied coverage if they are not showing ‘measurable improvement’ as a result of therapy” (aota.org). This ruling was the result of lawsuits filed by two women: 81-year-old Wanda Papciak who was denied therapy because her
“condition had not improved,” and 66-year-old Sandra Anderson who, after suffering two strokes, was denied coverage for the same reason. Both women filed lawsuits in their district courts (Pennsylvania and Vermont respectively) and both judges ruled in their favor. These original cases snowballed into a class action lawsuit, and the Washington Post reported, “Medicare spokeswoman Tami Holzman said that the agency is ‘working to implement the terms of the settlement and ensure that beneficiaries have the access to the full range of services that they are entitled to under the law’” (Jaffe). The AOTA subsequently published a statement indicating, “The elimination of the ‘improvement standard’ is a win for occupational therapy” (aota.org).

However, after these cases were settled, Medicare representatives claimed that the so-called “improvement standard” was actually the result of a deeply entrenched practice of interpreting an ambiguous section of the law as a prohibition of maintenance therapy. Medicare argued, emphatically, that there was no specific language in the law barring reimbursement for therapy that maintained a client’s existing capabilities where this was the best possible outcome, given a degenerative diagnosis. And, the written settlement from the recent court cases appears to validate this position. The settlement reads, “Nothing in this Settlement Agreement modifies, contracts, or expands the existing eligibility requirements for receiving Medicare coverage” (cms.gov). Instead, the mandate from the court was that Medicare must create educational materials “aimed at correcting long-standing, widespread misconceptions about the Improvement Standard.”
The misconceptions that the court highlights are the result of assumptions made and then sustained for decades. At some point after OBRA was passed, a Medicare compliance officer, or a series of such officers, rejected claims for reimbursement from occupational therapists treating clients for the purpose of maintaining their quality of life. And a series of therapists adapted to this practice. This interpretation – this assumption – became a reified boundary object, left largely in place for over two decades. Even after the class action lawsuit, this adaptation remains habitually entrenched. Tia explained, “I still encounter therapists at who are not aware of this ruling – who still believe that maintenance is not an acceptable goal for therapy.” Where practices or beliefs are deeply entrenched, Tuomi-Gröhn suggests that effective boundary crossing is characterized, in part, by the creation of new, advanced practices. She indicates, “The ethos of learning is to investigate and reconstruct, instead of adapting to existing practices” (206). Vicki investigates and reconstructs through the appeal letters that she uses to win reimbursement for therapy to treat those with degenerative cognitive disorders – those with little or no hope of improvement. She began to do this twenty years before the recent class-action lawsuit explicitly indicated that such therapy was appropriate, viable treatment.

In a study of IT professionals and healthcare professionals, Chris Kimble, Corinne Grenier, and Karine Goglio-Primard describe the role of brokers in boundary crossing. Referencing Wenger, these authors describe this role in the following way:

Brokers are members of multiple communities...To be effective brokers need to have authority within all of the groups to which they belong. They need to be able to evaluate the knowledge produced by the different groups and to earn the trust and respect of the various parties involved (438).
Certainly, numerous studies have corroborated these broker characteristics. However, Vicki’s success as a broker cannot be attributed to authority in the Medicare community of practice. She never met the people to whom she was writing. My research did not include a conversation with a certified professional compliance officer, but I am willing to suggest, based upon the job description, that the decision to reimburse for care as a result of an appeal letter was based less on trust and respect, and more on recognition of familiar language from the law, which Vicki and her colleagues intentionally used to formulate responses to the original denial. And, ultimately, while Vicki never directly impacted the national conversation, it is conceivable that the two patients who chose to sue Medicare were encouraged to do so by one therapist who understood the power and potential of writing back across the boundaries.
CHAPTER FIVE: CONCLUSION

In the preceding chapters, I have presented narratives from the literate practices of four occupational therapists. While this was, therefore, a limited study, the resulting data is congruent with findings in an overwhelming number of writing and rhetoric studies focused on the connection between writing and identity. The findings outlined here add in some small way to the chorus of scholars calling for the naming and examination of the consequences of imposing translation from one genre, form of writing, or activity system to another.

Summary

The four participants in this case study use and create an almost unlimited range of genres in their work as occupational therapists. These genres, ranging from narrative observations recorded on lined paper to standardized forms, facilitate a broadly bounded activity system that takes, as its primary focus, the life of the whole patient. However, the use of these genres does not occur in isolation. In order to be reimbursed for their work, occupational therapists must communicate with third-party payer activity systems, such as Medicare. The genres of occupational therapy are not recognized or used by such systems, so communication of the therapists’ practices requires translation from the profession’s genres to the genres created by the relevant payers. These forms increasingly reduce and constrict records of occupational therapy practice until they become a simple, five-digit code, which is read by Medicare employees as reimbursable, or medically necessary. Such codes not only obscure the narrative recorded in the original patient care genres, but they also exclude much of the therapists’ work from reimbursement. For instance, leisure activities are not considered medically necessary, and
are therefore not assigned a code for billing. However, such activities are directly tied to the central role that patient occupation plays in the work of occupational therapists. Because occupation refers to anything that occupies a person’s time, common items such as basketballs and knitting needles become the tools of occupational therapy when they are relevant to a particular patient’s goals. This approach makes occupational therapy unique among the health professions that are generally focused more exclusively on disease, rather than those activities that made a person’s life meaningful before, or will continue to create meaning and purpose after, a diagnosis.

Discovering and honoring occupation requires that occupational therapists share agency with their patients. This is evidenced by genres used in their practice that allow patients to participate in determining what tools and goals will be the focus of their therapy. This shared agency, however, along with the related use of everyday objects, has made occupational therapy difficult to define, causing significant anxiety about the identity and viability of the profession as expressed in journals, annual lectures, and other materials published by the American Occupational Therapy Association. The concern for professional viability is heightened because this little-understood discipline possesses limited authority within the powerful systems, such as Medicare and the American Medical Association, that control what counts as reimbursable care. This has resulted in double binds that not only create identity confusion, but which also leak back into practice, precipitating a drift away from a clear focus on occupation in practice.

As a result, the profession and its members have made attempts to broker communication and cooperation between their own activity system and other, conflicting systems. Efforts at the
level of the AOTA have included direct advocacy as well as a branding campaign that provides marketing materials to its members. These materials include question and answer sheets and wallet guides that provide a concise description of the profession to be used in conversation with patients, colleagues, family, and friends. The study participants treat such materials with skepticism. This is perhaps, in part, because such genres position occupational therapists as people who are unable to explain their own work. Additionally, this campaign, designed to forward an understanding of the profession, is disconnected from actual practice. A different, and perhaps more successful, effort to broker work across boundaries is found in the writing of appeal letters to Medicare. These letters often result in the reimbursement of care previously denied for payment, despite the fact that the author of such letters lacks membership or authority outside of the occupational therapy community of practice. Her efforts are more effective than the AOTA campaign, in part, because they reflect the profession’s values by creating letters that are directly connected to care for a particular patient. These genres position their user as an expert, even where she does not have pre-existing authority, and they act as an extension of her practice as a therapist.

**Implications**

Despite the small number of participants in this study, the narrative presented here of the work and professional identity of four occupational therapists has implications that are familiar from a significant number of writing studies about the strong relationship between literate practice and identity. In particular, these observations emphasize the consequences of translation, both from one genre to another and from one system to another. Translation is a necessary
element of interaction between activity systems. However, the five-digit codes that are the final expression of healthcare providers’ work serve as a somewhat extreme reminder that requiring translation is an exercise of power, often occurring at a significant cost to the translator. What follows here are implications from this data set for both occupational therapy and writing instruction that join existing observations about best practice in teaching and advocacy.

**Occupational Therapy**

The textbooks devoted to documentation in occupational therapy include significant instruction regarding the completion of treatment and assessment forms. However, the curriculum does not appear to include what Bawarshi refers to as “critical awareness of genre” (197). Perhaps, then, a series of questions could be developed to integrate such awareness into existing documentation instruction in the field. For instance, conversations about how to fill out a SOAP note (an acronym for Subjective, Objective, Assessment, and Plan), could be accompanied by questions about the identity constructed by this particular approach to documentation. For instance, everything the patient says is noted in the “Subjective” section of the form, and everything the caregiver observes is noted as “Objective.” What affordances and constraints do these categories create? How does this identity position of the patient as somewhat unreliable relate to the patient-centered care that is so key to the identity of occupational therapy as a profession? To supplement this conversation, data used in this thesis, such as the changes evident in the HOPE Clinic documentation, may be examined as evidence of the ways in which translation changes a local genre and practice. The four study participants have already suggested that such questions and discussions could be piloted in the curriculum at the research site.
The participants in this study also maintain more than three hundred active clinical contracts with practitioners in Florida and more than a dozen other states. Chris, Ron, Tia, and Vicki often host continuing education courses for these practitioners. Perhaps the critical genre awareness curriculum developed for the university could translate into a continuing education course that invites practitioners to bring the forms most frequently used in their practice sites in order to use these forms to guide a conversation about the identities that these genres create and sustain for them as professionals. Ultimately, this may initiate conversations that could extend to practitioners from other healthcare disciplines and administrators working with the occupational therapists at these sites. The participants have also expressed a desire to co-create articles for submission to the “American Journal of Occupational Therapy” and presentation proposals for the AOTA national conference to further explore some of the findings presented in this thesis.

**Teaching**

Professors, particularly those who teach composition, are in the business of requiring translations from students. Individuals bring original identities into the academy, and graduation is the result of a series of translations from familiar genres and ways of speaking to essays and research papers and reports. Russell writes, “Classroom genres are linked intertextually to written genres of the university activity system: student papers are commodified into grades placed on student papers, which then are further commodified in grade reports, which are collated into transcripts and so on” (530). Much work is being done in composition research and pedagogy to honor the identities and languages and genres that people bring with them to school. Victor Villanueva, Mike Rose, Geneva Smitherman, Malea Powell, Keith Gilyard, Adam Banks,
and Gloria Anzaldúa are scholars who have worked, some for decades, at the border. They have called for students’ rights to their own language to be meaningfully practiced in the academy. Gilyard wrote, “A pedagogy is successful only if it makes knowledge or skill achievable while at the same time allowing students to maintain their own sense of identity” (11). These scholars, and others, have also long warned of the consequences of forced translation. Anzaldúa quotes Ray Gwyn Smith, asking, “Who is to say that robbing a people of its language is less violent than war?” (34).

However, much activity in composition classrooms still demands the unconsidered adoption of new languages and new identities, and such translations are not without consequence – they show up in communities outside of the classroom in ways that often erode identity. It is worth considering how we might stop centering our identity as educators in the tools or genres that are created in the classroom, and understand our expertise to be in employing those tools that are important to students in order to give them increased power. Approaches to teaching documentation in the professions should mirror best practice already applied in writing instruction – namely, that to teach writing anywhere is not the simple reproduction of selected genres. Rather, to teach writing effectively is to have explicit discussions about the affordances and constraints of genres – about what is lost in translation and the resulting material consequences for practice. Where we focus exclusively on our products, rather than the processes, of writing, we are in greater danger of compromising, rather than strengthening, our students’ unique identities. The expertise of the four occupational therapists that I interviewed is not defined by the tools that they employ, but rather by their understanding of how to use tools
that are important to their patients. In authentic occupational therapy, experience that a patient brings to the interaction with an occupational therapist is valued, and adopted by the therapist in practice. This approach draws broad boundaries around what counts as knowledge. Further, the four occupational therapists that I talked with actually move the site of their practice to their patients’ homes, to the basketball court, or to the swimming pool – the physical space of their client’s occupation. It is worth considering how the academy might more frequently and meaningfully cede geographic territory and move the practice of education to sites familiar to our students, rather than visiting them as excursions or novelties. In his work tracing literate practices as resources remediated in a range of genres from a broad collection of times and spaces, Kevin Roozen argues:

The work we need to invite learners to do seems less about employing extra-disciplinary practices only with an eye toward replacing them at the first opportunity and more about encouraging learners to view them as flexible resources for creating, maintaining, coordinating, extending, altering, and perhaps even productively disrupting networks that provide access to disciplinary expertise; to develop a sense of the linkages and the incommensurabilities and affordances and constraints that animate those networks; and even to consider not just what textual practices were in previous *thens* and *theres*, but how they might function here and now as well as in the near and distant future (348-349).

Honoring the genres and places that are important to our students outside of the classroom still generates anxiety about disciplinary identity and viability. There are parallels between this concern and the identity anxiety expressed by occupational therapists, particularly where the potentially commonplace nature of our tools and our interest in our students’ point-of-view are concerned. Jody Shipka writes, of reaction to her use of unorthodox, student-generated composition forms, “Some of the questions lurking behind the reaction seems to be, ‘How is *that* college-level academic work?’ ‘How can *that* possibly be rigorous?’, or ‘How can allowing
students to do *that* possibly prepare them for the work they will do in their other courses?” (2). However, the centrality of the student, or the patient, is the very thing that gives our respective professions their unique position in their particular spheres of influence, and it is worth remembering that failing to embrace the tools and practices of such difference is, in fact, the very thing that will most threaten disciplinary identity, relevance, and longevity.

**Advocacy**

There are also implications in this narrative for individuals who must broker between conflicting communities of practice. First, such brokering seems most successful when it is facilitated using genres that are remixed, maintaining clearly recognizable elements of language from both activity systems, rather than translation that erases traces of at least one original. If the boundary object is constructed in this way, the broker does not need to have, as many writing scholars have suggested, membership or authority in both activity systems. This is largely because a boundary object that honors language from both systems also honors the identity of its users as experts. In this way, Vicki incorporated the language of genres generated by both occupational therapy and the laws that governed Medicare in her appeal letters, creating a genre that was recognized in both systems by maintaining the identity of each. Vicki does not have pre-existing authority with Medicare, but the appeal letters that she wrote drew on her expertise and positioned her as an educator who remixes her own practice with Medicare’s requirements to win treatment for her patients. The letters, therefore, become an extension of authentic practice.

This narrative also provides some commentary on the role of national or state organizations and large employers in advocating best practice. A large organization has the
responsibility to use its resources to hold space open for authentic practice (for instance, by incurring costs up front) so that individual members can act upon their expertise. Perhaps it is the job of national organizations, or even universities, to create what Rita Charon refers to as “clearings” in the dense forests of conflicting experiences and priorities until best practice becomes commonplace. Where teachers of writing, for instance, are crippled by state or federal regulations, local school district leaders or universities must have the courage to encourage individual teachers to follow best practices anyway, and then appeal funding decisions through genres that describe the material consequences to the student if such practice is discouraged or denied. Vicki’s employer, a national therapy staffing agency, encouraged her to pursue best practice followed by the creation of appeal letters. The agency’s motivation is, certainly, financial, as successful appeal letters result in reimbursement for previously denied care. However, the same agency could have avoided the time and effort required to write appeals by simply forcing therapists to compromise the way that they delivered care from the beginning. It is more costly to deliver the correct care and fight for its recognition than to compromise in the initial exchange. Vicki repeatedly suggested that her role was to educate Medicare – to ultimately make correct care a reimbursable option without appeal. The staffing company assumed the risk and responsibility, because the outcome was not guaranteed. The letter may not have been successful, and the patient may not have been able to pay, but the company allowed its therapists to ask for forgiveness from the third-party payers for having already engaged in best practice, rather than permission ahead of time to do so.
This data suggests, then, that if language is to act as an effective boundary broker, it should follow action. Brokering between conflicting communities seems most successful when it is directly related to a specific, compelling narrative – in this case, reimbursement has been denied for care received by patients. Writing an appeal letter is not an act of abstract introduction or a discussion of best practice, but rather an appeal for a specific need. These observations suggest, however, that language is not material, while physical interaction is. As I finish this thesis, I am reading news about the shooting of nine individuals in a historic, AME church in Charleston, South Carolina. The shootings were carried out by an individual who made public his racist, vitriolic identity via a website, and then committed acts of murder as an extension of his violent ideology. I write, therefore, with some discomfort about my findings regarding the necessity for written advocacy to be bolstered by narratives of embodied denial. There has been a great deal of attention paid to the language of the shooter in Charleston, and a great deal of attention paid to the commentary about race and flags and symbols, now that these words trail violent action. However, Anzaldúa, Foucault, Powell, and many others have argued that language is action. Language is material, consequential, at times violent – language is practice. The leap from the denial of healthcare to the appalling murders in Charleston is perhaps a leap too far. However, it seems important to pin this writing about identity and language to this point in history, because these narratives highlight the danger of assuming that language is cheap. These narratives remind us that websites and laws and forms are material acts already, and that waiting until they “turn into” practice is to miss the point, sometimes with unimaginably terrible consequences.
Opportunities for Further Study

Although the data presented here provides a glimpse into the literate practices of occupational therapists, there are several research questions that emerged during this study that, if pursued, would productively extend the findings outlined here. Here are three such questions.

*How do the personal histories of occupational therapists inform professional practice?*

The four participants in this study were gracious enough to discuss some of their personal histories before they chose to enter occupational therapy as a profession (childhood, family, personal belief systems, etc.). The pursuit of expanded narratives from these participants’ whole lives could be an opportunity to add an important layer to this study, which emphasizes the attention occupational therapists pay to the whole lives of their patients.

*What dispositions enable new practitioners to maintain professional identity?*

Each of the occupational therapists that I interviewed spoke from decades of experience in the field. Additionally, the therapists whose voices are represented in the publications and lectures that I read are also experienced and established practitioners. Observations of occupational therapy classrooms and clinical sites, along with student case studies, would allow for data on the current practice of enculturation for new occupational therapists, particularly as the healthcare environment that they are entering continues to change. Conversations with current students and new practitioners may allow for examination of the points at which new practitioners feel the first pressures to compromise the authentic practice of occupational therapy that they learn in the classroom. Studying these moments of initial tension may also provide some sense of the dispositions that factor into decisions to write or practice back to such
compromises, as well as some insight into ways to foster such courage in students and new practitioners in any field, including composition and rhetoric.

*What factors surround the creation of genres like the AOTA’s brand toolbox?*

The AOTA is likely not the only organization to have struggled with the challenge of meaningfully supporting its individual members. Conversations with those individuals who worked to create the genres presented in this thesis would provide insight into the history of such genres. There are existing studies that focus on patients and billing agencies, but few studies explore the national accrediting bodies associated with healthcare professions. A case study with the leadership of this group would, in particular, enrich the discussion about brokering explored in chapter four of this thesis.

For these four therapists, the language and literate practices that mediate their work are so integral to their professional identity that adopting another language is to adopt another identity, and this alternative identity is not, to use medical terminology, benign. It works its way back into practice in ways that Chris, Ron, Tia, and Vicki cast as detrimental to their work and their patients. Further, such translation is so pervasive that even in the rare setting that is self-contained, like the free clinic established by Ron and Tia, genres and practices still evidence traces of third-party payer systems. This example is a call, therefore, not for the elimination of translation, but for more explicit naming and conversation about the resulting consequences. On a very personal level, such awareness may empower small acts of resistance, such as the choice to include personal history in the qualitative sections of the forms that we complete in any
number of professional settings, even where genres do not invite such writing – to make our whole lives matter by writing them into existence.
APPENDIX: IRB LETTER
Approval of Exempt Human Research

From: UCF Institutional Review Board #1
FWA00000351, IRB00001138

To: Stefanie Johnson

Date: November 25, 2014

Dear Researcher:

On 11/25/2014, the IRB approved the following activity as human participant research that is exempt from regulation:

Type of Review: Exempt Determination
Project Title: Genza and Identity in Occupational Therapy Evaluation Discourse and Documentation
Investigator: Stefanie Johnson
IRB Number: SBE-14-10704
Funding Agency: N/A
Grant Title: N/A
Research ID: N/A

This determination applies only to the activities described in the IRB submission and does not apply should any changes be made. If changes are made and there are questions about whether these changes affect the exempt status of the human research, please contact the IRB. When you have completed your research, please submit a Study Closure request in iRIS so that IRB records will be accurate.

In the conduct of this research, you are responsible to follow the requirements of the Investigator Manual.

On behalf of Sophia Dz涅lewska, Ph.D., L.C.S.W., UCF IRB Chair, this letter is signed by:

Signature applied by Joanne Musatori on 11/25/2014 03:30:17 PM EST

IRB Coordinator
LIST OF REFERENCES


Wardle, Elizabeth. “Identity, Authority, and Learning to Write in New Workplaces.”


Wenger, Etienne. Communities of Practice: Learning, Meaning, and Identity. New York:

