Canadian and Japanese associations of occupational therapists: trends in their professional activities and education during the period 1982-2001

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Canadian and Japanese associations of occupational therapists : trends in their professional activities and education during the period 1982-2001

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ABSTRACT

This study is to explore the trends of the occupational therapy profession in Japan and Canada. Japanese Occupational Therapists have been influenced greatly by Western countries. Now, many Occupational Therapists in Japan think that it is the time to shift from the conventional medical model to another framework more relevant to contemporary practice. Canadian Occupational Therapists have already integrated social change and developed more responsive Occupational Therapy (OT) practice models. From reviewing trends of the OT education programs and the associations of OT and workplaces, there were indications that the number of Japanese Occupational Therapists had increased more rapidly than that of Canadian. Japanese Occupational Therapists workplaces were at hospitals and in communities, while workplaces of Canadian Occupational Therapists changed from the institutions to communities. It would be predicted from the differences that Japanese Occupational Therapists might be in confusion of practice between medical models and community models. With the shifts brought about by global paradigm changes in medical and health care, it is wise to work collaboratively to understand each other's culture and appreciate new knowledge.

KEY WORDS

Canada, Japan, Occupational Therapy, Trend, and Practice model

Introduction

The home care insurance system was introduced in Japan in 2000, within the framework of reforms of the medical insurance system, to cope with the aging of society. Information on this new system began to be disseminated several years before its introduction, through the media and various related organizations, committees. The national and local governments assumed the primary role of preparing for the introduction of the system[1-3]. This new system caused a shift in the care of elderly people from conventional medical care in hospitals to regional health-related welfare services. This shift is expected to impact greatly the work of Occupational Therapists that are professionals in the field of medical and health-related welfare services. Furthermore, amidst the wave of globalization of concepts in medical and health care professions, the International Classification of Impairments, Disabilities and Handicaps (ICIDH) was revised, and a new model for describing disabilities, called the International Classification of Functioning, Disability and Health (ICF), was instituted by World Health Organization (WHO) in 2001[4,5]. This reform will also be a factor making a large impact in the future. Today, when Japanese government intends to make reforms, we do not have a clear perspective on

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the Occupational Therapy (OT) role will play in this country in days to come. Under these circumstances, an analysis of past trends of OT and identification of problems within the field in Japan will be useful for establishing the direction Occupational Therapists and other related professions should take in the future. In the past, few such analyses of the field were carried out. Most of the information released to date, concerning trends in Occupational Therapists' practice, was supplied in the forms of advertising activities, news releases or papers published by individual Occupational Therapists or their professional organizations. We cannot be clear to what extent these pieces contain educational elements on the one hand or quite subjective views on the other. Therefore, if several pieces of information are selected from these sources and simply combined, the resultant picture about the trends in the field in this country may be biased. However, even though some pieces of information or conclusions offered may be biased, the phenomena or events dealt with in these promotional releases, news items and papers can be viewed as reflecting current topics in this field. Based on this expectation, the authors recently attempted to collect key words from papers published in the journals published by Occupational Therapists' organizations excluding academic papers published after review by referees and to rearrange them in a time-ordered sequence, with the goal of analyzing recent trends in this field. Historically, OT in Japan actively learned its therapeutic theories and models of therapy from Western countries. The Canadian system for qualifying for membership in the profession of OT is closer to that of Japan than is the one used in the United States, and close attention is now being paid in Japan to Canadian models of medical education and OT that have recently been put into practice in Canada. We therefore expected that comparing the trends in Japanese OT with those in Canadian OT would contribute to characterizing the Japanese OT and would thus be useful for gaining a perspective for the future of OT in Japan. The sources of information used in this study were: the official journal published by the Association of Canadian Occupational Therapists (CAOT) -- i.e., the Canadian Journal of Occupational Therapy (CJOT); and that of the Japanese Association of Occupational Therapists (JAOT) -- i.e., the Journal of the Japanese Association of Occupational Therapists (JJOT). The papers investigated were those that present commentaries or opinions published in these journals during the period from the 1980s when the first JJOT was published to 2002.

Methodology

A list of key words was prepared by extracting key words from the titles, paragraph captions, key sentences of national speeches and position papers written by the presidents and directors of both OT associations that primarily contained historical information or statistical data, as well as papers presented at symposia, memorial speeches. Statistical data on OT in Canada was found in many papers. In Japan, statistical data on OT was not found among the papers listed in the statistical information published in each issue of the OT Association's official journal for a certain period. Therefore, the data given in the chronological table contained in a white paper on OT in Japan was used for preparing a list. Furthermore, in Japan, many position papers (excluding academic papers) contained no references, used abstract (nonobjective) words in the title and offered no key words. Thus, the number of key words extracted from papers differed between Canada and Japan. To make up for the shortage of extracted key words, we chose words and sentences used in chronological tables of Japanese papers to use as additional key words. The key words thus extracted were divided into three groups: (1) key words pertaining to general social events and phenomena, (2) key words pertaining to social aspects of OT, and (3) key words on professional aspects of OT. Key words of the same or similar meaning were combined into an upper level topic word. Topic words pertaining to general social events and phenomena were assigned to the category of "social background related to the aging of society ". Social topics related to membership in the profession of OT were assigned to the category of "occupational therapists' professional associations". Topic words pertaining to professional practice aspects of OT were assigned to one of the following three categories : "the education of OT", "the OT

practice and workplace of Occupational Therapists" and "models and theories for OT". In total, 5 categories of topic words were prepared. In both Japan and Canada, topic list tables were prepared for each of five periods that each spanning was 5 years during which the individual events occurred. On the basis of these tables and the contents of key sentences, chronological trends were described and distinguished from each other by their relationship to health care reforms. These five topic lists were prepared separately for Japan and Canada. Changes in characteristics, as analyzed from three perspectives --i.e. Occupational Therapists' associations, the education of OT, and the OT practice and workplace of occupational therapists were represented graphically to illustrate trends in both countries.

Results

The number of topic words by category and country were as follows: the category of social background of the aging of society had 25 entries in Japan and 24 in Canada, the category of OT association - 39 for Japan and 43 for Canada, the category of OT model and theory - 9 for Japan and 22 for Canada, the category of OT education - 19 for Japan and 14 for Canada, the category of OT practice and workplaces of Occupational Therapists- 29 in Japan and 30 in Canada, and for the total of all categories 121 in Japan and 133 in Canada. As shown in the tables (table1 and 2) listing topics related to the aging of society, measures to deal with that phenomenon began to be reflected in the topics discussed in both Japan and Canada in the 1980s, when the percentage of aged people in both countries was about 10%. Common changes observed in both countries during the period from the 1980s to the 1990s included demographic changes from the aging of society to the aged society, economic changes --i.e. economic recovery from a slump in Canada and the beginning of an economic slump in Japan, technological changes -i.e. information technology, medical and health care technology, social movements -i.e. increases in the power of consumer groups, the emergence of the information age and of litigiousness.

The timing and details of health care reform related to the associations of Occupational Therapists and the measures taken in each country were the following.

Trends in health care reform in Canada (Table 1)

In Canada, a policy paper was issued in the second half of the 1980s, instructing all allied health organizations to establish a system based on the team approach. To cope with this health care reform, the CAOT began to prepare nationwide standards and guidelines for OT in the 1980s, to provide a base for relationships with other allied health professions. After 1985, the same organization also prepared outcome measures and conducted research to demonstrate the effectiveness of OT, leading to their proposing three tasks for establishing Occupational Therapists as a significant component of health care teams. When the designated task forces had succeeded in implementing their tasks, the CAOT published three central concepts toward a practical model of OT, i.e., the holistic model, the team approach and client-centered relationships. Changes in the practical model were prepared in the 1990s.

In the 1990s, adoption of a policy of health care reform was accompanied by large-scale dismissal of the allied health professions working in hospitals. Therefore, we might say that the measures taken to deal with health care changes in the 1980s advanced from the preparatory stage to the stage of enforcement around 1990. We therefore identified the 1980s as the period when reform was penetrating the health care field, and the 1990s as the period when reform was being implemented.

However, opinion papers published by CAOT presidents and directors in the 1990s used such key words as "historical identity crisis", "old and new OT", "complications" and "changing practices", which suggested disturbances in their sense of professional practice. In the second half of the 1990s, partnership agreements involving the 4 groups were concluded, involving the CAOT, the Canadian Physiotherapy Association, the Canadian Nurses Association and the Canadian Dietetic Association. Ethical guidelines were completed, and a business cooperative between the CAOT and Shoppers Drug Mart that provided various health care services including a devise and a wheelchair was initiated. In the second half of the 1990s, the Community Care Access Center, which served as the core of regional care systems, began to function,

Table 1. Canadian trend of 5-topics lists

Term	Year	Background / Social Event	CAOT	OT MODEL/THEORY	OT Education	OT PRACTICE/ WORK PLACE
準備期 Preparating for the health care reform	1980	65+population;8.1% (1971) Budgetary restriction Old people institutionalized Consumer group Legal system change	OT membership: 973 (1980) Organizational growth Registration: importance of standards "Guideline for practice of OT" published Strengthening ties with provincial OT association Task forces developed three publications: Practice, Intervention Outcome measures	A body of broad knowledge Organized into theory Scientific and social disciplines the General model "Occupetional Performance Model" Human occupation	Byond to basic professional education program Administrators knowledge Lifelong education	Changes take place in the health care Delivery system Hospital-baced to Community based Quality assurance Changes move slowly
	1985	Technological change Increasing immigrate people Immigrateclients "All Allied Health Organizations Our Team by government policy papers	OT definition reviewed; the need of borad reac the first "National Certification Exam." (1986) CAOT Long Term Plan; long term is three years instead of five or ten Professional data based OT practice Health promotion strategy Marketplaces changing; research of "OT job satisfaction" increased OT membership; 4569 (1989) Innovative community based programs	Community model Process model Global or holistic approach Corporate model; management system Consultant model Culture Model for broadly assessment	OT graduate program Fieldwork performance evaluation form Beyond the transmission of professional Knowledge; critical Thinking, problem solving decision making ability, flexibility CAOT university programs	OT in a Hospital/Private practice Malpractice Career planning Chronic, old age and disease a Validity study of guidelines for wheelchair selection Measurement insturument; predict recovery, treatment effect Ontario's critical shortage of OT Clinical research
実行混乱期 Action Adapting–confusion	1990	65+population;11.6% Changing time, globalization, economic conpredictability, urbanization Information & Litigious society Health care reform Rising cost of social program Slow economic recovery	" OT Guidelines for Client-Centred Practice" published (1991) OT's historic identity crisis The old and new OT complications Consolation, Consolidation, Re-definition Clinical reasoning, Ethical decision making The autonomous therapists increased Professional corporations Changing practice Health promotion Beginning of the deinstitutionalization of OT	Community OT models Ethics Variety of service delivery models Culture values	Innovative fieldwork Professional ethics Moral responsibility and OT education	Multiculturalism "Client-Centered Practice" Increasing community services Replacement workers; career mobility "We have already successfully begun to break traditional health values and into the community"
実行安定期 Action Adapting–stable	1995	65+population;12.2% North American free trade agreement Program for North American mobility in higher education Senior initiative project start "Community-Care Access Center" start International year of older persons Senior population the fastest growing	Partnership with the Canadian Physio-therapy Association, Canadian Nurses Association, and Canadian Dietetic Association (4G) to address the concepts of integrated " A Guidelines to Profeasional Responsibility for OTs" published (1996) Health human resources development Strategic planning; organization, administration, promoting public, key result areas Cooperation with "Shoppers Drug Mart" Pressure to provide evidence-based Practice by linking outcome "Evidence-based Practice Tool" published	the Funding model of maneged Health care in US Evidence-based OT Evaluation research; dicision making, accountability "Occupational Science"	Higher education International education Standards of education -accreditation Leading the way in "Fieldwork Education Site" approva	Client-driven Changing from full-time traditional job to part-time, temporary, contingent employment Confusion in workplace Dilemma of balancing quality care with cost effective the Art of OT Practical reasoning processes Quality of health care Health human resources Resource allocation
	2000	65+population;12.6% New money becoming available for health and social services	"Professional Development and Reflective Practice" published "History-Canadian Occupational Therapy Foundation(COTF)" promote "Tool Kits to Support Personnel" developed OT membership: over 6,500	Spirituality		Profession's value system "Thory-Practice" link Well-informed the Core of "Client-Centred Practice"

Table 2. Japanese trend of 5-topics lists

Term	Year	Background / Social Event	JAOT	OT MODEL/THEORY/RESEARCH	OT Education	OT PRACTICE/WORK PLACE
準備期 Preperating for Health Care Reform	1980	"Bed ridden Elderly": more than 5000 65+population; 9% Ageing society Medical payment system reform "Senior Health Law" established Prosperity (a boom)	OT membership: 752 (1980) JAOT applied for the corporation aggregate theJournal of JAOT (JJOT) strated Request (payment system) to MHW 2 OT text books published Discussion of "Difinition of OT"	Individual clinical experiences/ case study(-1992)	OT schools: 24(1983) the OT/PT school's teacher training course start by MHW	Most of OTs work at hospitals
	1985	65+population;10.5% "Pension plan" revisioned Disabled person's basic pension system "Techno-Aid Association" Co-medical qualification system "PT/OT human resourse supply & demand plan" reviewd by the MHW	the "OT Report in 1985" published 8 OT textbooks published OT membership;over2000 Reqeest (revision of Mental Health Law, PT/C school rules) to MHW: Three Associations (JMA, JAPT, JAOT) talks about sharing "Community based rehabilitation" workshop with JAPT OT human resourse reviewed OT membership; 3387 (1989) Plan of OT guideline	Clinical reasoning of OT	Plan of OT curricuram and OT ethic OT schools: 28 "Tokyo Medical College" Starts the new plan of OT curriculum(1985-88)	Stroke, Hemiplegia Adominstration, management and organization in the occupational therapy facalty at a hospital Fields of OT discussed Roles of "Senior OT" the Disabled elderly WFOT
	1990	65+population;12.1% "Gold Plan for the medical and health care system" starte Recession/Financial crisis "New Gold Plan" start Medical payment system reform Request for PT/OT supply & demand plan by the Japan Medical Association to MHW "Criterion of care equipment" formed "Standard of Nusing home" reviewed	Request (payment system) to MHW "OT Guideline (1991)" published "OT textbooks series " published (1991-96) Plan of JAOT organization reform "OT Report in 1991 " published Projects ; OT effect and CVA start "OT Practice Manual" series start OT membership: over 5,000 (1993) Change from "controlled approve" to "controlled notify"	(Kielhofner came to Japan) OT research Research project "Equipment for Elderly"	OT schools: 33, Rush of schools Higher education; a new degree for college students the First university education(1992) Lifelong education	Work&workplaces in medical and health care fields Facilities in community OT practice in mental health Clinical trial of medical devices New workplaces increase the Disabled elderly Community
	1995	65+population;14.5% "Promotion/treatment at Home" reviewed "Long-Care Insurance" Established	OT membership: over 6,000 (1995) "OT Guideline-Revised" published "Welfare Tools Planner" workshop "OT Report in 1996" published 15 Requests (payment, education, mental health) to MHW "Opera" OT advertising magazine start "Home Care Assessment and Care Plan Tools" published OT membership: over 10,000 (1999) Projects for "Long-Care Insurance"start 1,471 OT members pass the First Exam."Care Support Profession"	Research project "Electric Bed" Frame of understanding of patients and cl Concepts on OT	OT Schools: 58, Rapid increasing OT clinical education; fieldwork, clinical training Master, Ph.D. course Open (1994, 1999) Curriculum revised	"Community Health Care Law" Activities in OT practice Special interest groups Home environment & teonology New medical qualifications Group treatment and activities on OT practice Approach to apraxia/ disturbance of behavior Individual clinical experiences
Action Term Adapting confusion	2000	65+population;17.5% "Long-Care Insurance" started	OT membership: over 13,000 "Care Manager" OT members: 2,215 JAOT organization reform "OT Report -2001" published	Evidence based medicine and OT	OT Schools: 107 OT lifelong education program on TV Improper questions in PT/OT national exam.	Team approach Market Principal OT roles in practice, Identity crisis Management, Critical path

Note: MHW=the Ministry of Health and Welfare

leading to the stabilization of the entire situation surrounding OT. We therefore identified the period from 1990 to around 1996 as the period of instability due to adopting reforms and the subsequent period as the period of attaining stability after adopting reforms.

Trends in health care reform in Japan (Table 2)

In Japan, reforms of medical care, and health and welfare services were planned and implemented, primarily under the Gold Plan and the New Plan, which were devised by the Ministry of Health and Welfare to cope with the aging of society. In the 1980s and 1990s, related laws were prepared or amended, medical payment reforms were implemented, and other measures were taken. These included promoting regional public health services, planning for the requirement for, supply of, and education of professionals involved in regional rehabilitation services, and preparing for introduction of the Long-Care Insurance system. This system was then put into practice in 2000. Throughout this period, the JAOT continued to submit written requests to the Minister of Health and Welfare, pertaining primarily to payment system related OT and the plan for supply of and demand for OT human resources. They also requested clarification pertaining to the practice and education of Occupational Therapists in the field of mental health. In the 1990s, textbooks for various individual fields within occupational therapy -i.e. physical disabilities, mental disabilities, child development, community-based rehabilitation and OT in Gerontology were published. After 1995, when membership in the JAOT rose to about 5,000, the organization of JAOT was reformed, and a major question : how we could enrich the continuing education of professionals was identified. A project team was organized within the JAOT to cope with the introduction of the Long-Care Insurance system planned for 2000, and JAOT Home Care Assessment and Care Plan Tools were prepared. As of 2001, the guidelines mentioned above remained unmodified, and there was no plan to introduce drastic changes in the basic model. The period from 1980 to 1999 was regarded as a long preparatory period, in line with the "Slow Landing" policy of the Minister of Health and Welfare, and we identified it as "the period of reform penetration." The period after 2000 when the Long-Care Insurance system was introduced, we named "the period of adopting reform."

There were main changes within the Association of Occupational Therapists, the system and curriculum of OT education, and the Occupational Therapist workplace in the context surrounding OT from 1980 to 1999. The characteristics of these three perspectives were graphically represented (Figs. 1 and 2).

Discussion

In Canada, a national examination for Occupational Therapists was first implemented in 1986[6]. In that country, the examination has been given by the CAOT under assignment from the Canadian government, using questions prepared by the CAOT. The CAOT was thus more actively involved in the national examination for Occupational Therapists than was its Japanese counterpart (the JAOT). In Canada, practitioners of OT are required to be registered with a province and the registration needs to be revalidated every year[7]. This system seems to greatly affect the education and practice of Occupational Therapists in Canada. Steps to prepare for establishing a comprehensive curriculum for OT education took place between 1985 and 1990. In 1990, an education program using the OT practice model was started within the framework of university programs. After introduction of this model, the basic professional program of education that had been offered previously was changed. Basic medical education began to be an optional subject from a required subject, as there was no question relating to Anatomy and Physiology in the national examination. However, basic medicine began to be seen as an optional subject rather than an essential subject, in line with the contents of the national examination. In the second half of the 1990s, an opinion paper arguing the significance of this change was published. At present, arts and crafts are only taught as material relevant in the history of OT. Clinical training began to be called "fieldwork education", and an internet web-site on fieldwork education was created, allowing students across the country to access this form of education. We might say that steps to prepare for implementing changes in the education system were taken during the latter half of the 1990s. Judging from the changes in key words found, it

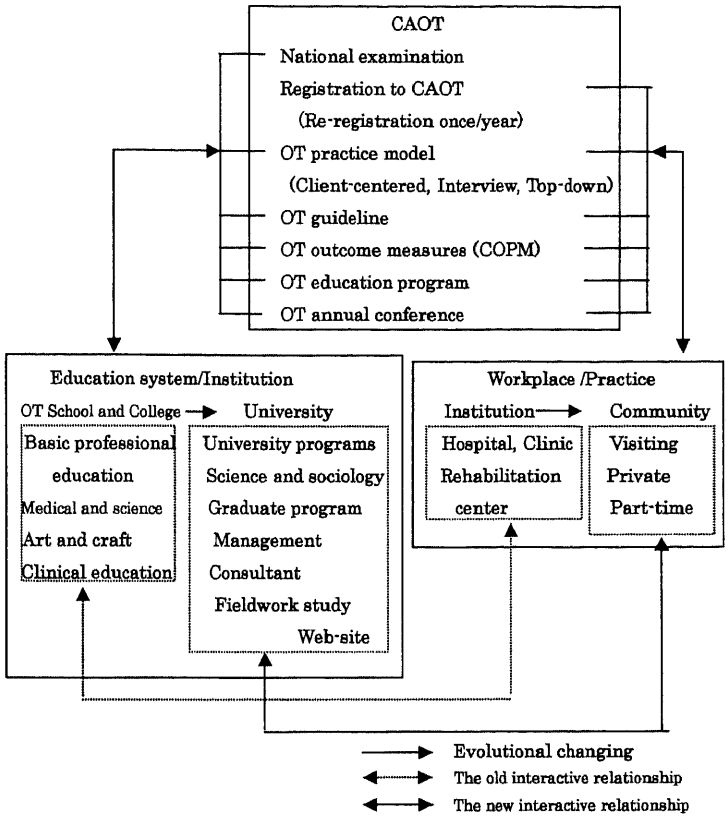

Fig. 1 Relation among CAOT, Education and workplace and their characteristic in Canadian OT

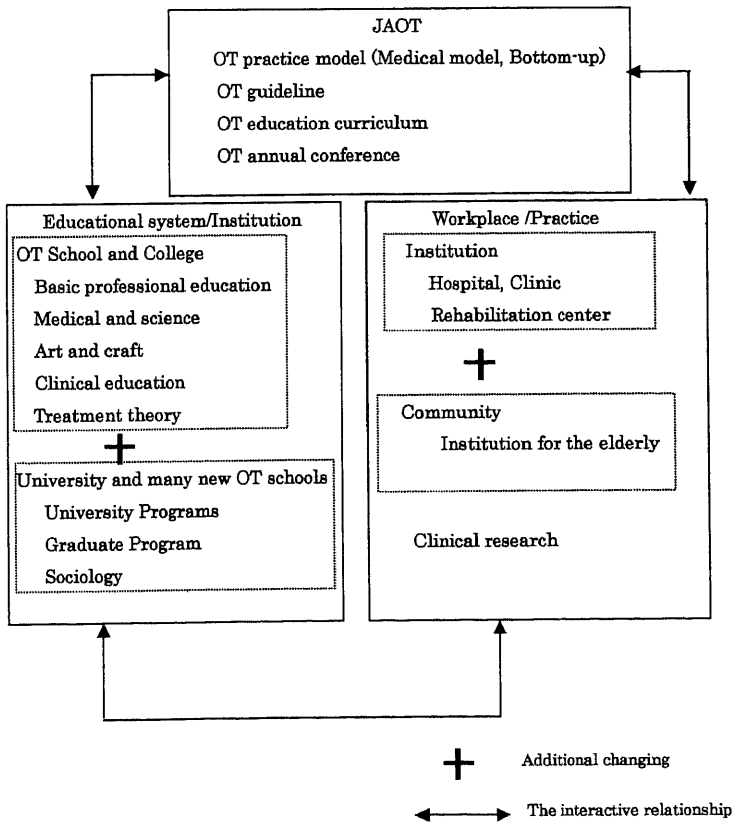

Fig. 2 Relation among JAOT, Education and workplace and their characteristic in Japanese OT

would be that the workplace of Occupational Therapists shifted rapidly from being located in facilities to being out in the communities during the 1990s. In the second half of the 1990s, the number of part-time or temporarily employed Occupational Therapists increased. The importance of quality issues and theory-practice links began to be pointed out by CAOT after 2000, suggesting that there are still unresolved problems pertaining to OT practice in the workplace. The CAOT completed its proposal for the new guidelines and OT education programs by 1990. Considering the temporal relationship, we might conclude that interactions between practice and education have been facilitated under the leadership of the CAOT.

In Japan, the JAOT prepared OT guidelines in the 1990s, aiming at improving the level of knowledge and skill for each type of disability field, through the publication of educational texts and manuals. The number of Occupational Therapists who are members of the JAOT has been increasing year by year[8]. Since 1995, educational seminars and workshops have often been held by this association. Steps to prepare for establishing education for students and members of the association were taken in the 1980s. Since 1990, efforts have been made to improve the organization so as to cope with the need for continuing education and for future changes, laying emphasis on how to cope with the increase in the number of members of the association. As far as OT education is concerned, high-level education to prepare Occupational Therapists was facilitated in the 1990s and the number of newly founded professional schools related to OT increased. This trend became more marked in the second half of the 1990s. Emphasis was laid on basic professional education. Basic medicine and "arts and crafts" were seen as essential subjects, and new subjects related to OT in Gerontology and community-based rehabilitation were added to the curriculum. As a result of these changes, shortage of places for clinical training and teachers continued until 2000. In the 1990s, the workplace for Occupational Therapists shifted from hospitals in the medical care field to the health care facilities for the aged in the field of health and welfare services. Until 2000, an overwhelming percentage of Occupational Therapists worked at facilities. Thus, changes were seen in the form of addition of new workplaces to conventional ones. JAOT often had no staff of an Occupational Therapist that could spend the entire time for the organizations. The activities of these organizations were supported by teachers and clinicians. Occupational Therapists who worked at hospitals or health and welfare facilities often were simultaneously researchers in their fields and supervisors in clinical education. There were thus close relationships among work, research and practice. However, the relationship and the balance among these elements varied depending on the nature of activities that were clinical training, preparing textbooks, preparing guidelines, and publishing association's news papers and journals. Leadership was not always defined clearly. Such a situation seems to be still prevailing at present.

Conclusion

In both Japan and Canada, the period from 1980 to 1999 can be viewed as the period of reforms in the health care system to cope with the aging society. To compare characteristics between the two countries, Canadian OT took a change the conventional model of OT in the medical field to an OT performance model[9,10] which is based on the new concept -i.e. "client-centered", to cope with the drastic social changes. CAOT attempted to overcome the challenges by implementing big changes in education and practice. The situation in Canada surrounding OT has become stabilized to some extent. We might say that CAOT had been autonomous as the professional organization, allowed CAOT to prepare for and implement such big changes. In Japan, where history and culture vary greatly from those in Canada, health care reforms are being implemented by modifying conventional systems, rather than replacing the conventional systems with totally new systems. The preparatory stage for reforms in Japan corresponded to the period when human resource was secured and post-graduate training for OT practice was enriched. After the Long-Care Insurance system was introduced, the medical and health care reforms entered the stage of enforcement. The reforms in Japan were about 10 years behind those in Canada where the preparatory

stage was completed in the 1980s. In Japan, the border between the preparatory stage and the stage of implementation is not clearly-defined. It would be not rational to say that implementation of reforms in Japan has been facing difficulties and confusions just on the grounds about 10 years behind.

The differences in OT between Japan and Canada seem to be related to differences in the history of OT before 1980 that the period not covered by this study, especially the difference in the presence or absence of the OT assistant system[11], as well as the difference in historical and cultural backgrounds. Therefore, the differences in trends in OT between the two countries represent differences in social adaptive activities. It is not rational to argue which of these countries is more adaptive. However, in view of the revision of disability model presented in ICF by WHO and the revision of the OT guidelines in the United States in 1994 and 1999[12-14], we might say that a global trend of OT is a shift from the medical model to the process model based on the top-down system characterized by team approaches and the client-centered concept as Canadian OT model.

Japanese Occupational Therapists would be in very complex dual situation that Occupational Therapists in Japan would be working on top-down models and. bottom-up practice. It would be a temporary confusion at workplaces but might continue for long periods of time. If this situation reflects the way of JAOT that uses totally different concepts and models in different fields of OT, the JAOT may deserve positive appraisal for its very adaptive approach to the current social situation. However, in view of the possibility that hospitals as a workplace for Occupational Therapists will be balanced with community health care services (another workplace) in the near future, the current way of JAOT would not be able to satisfy the need of providing adequate education on both models at universities and professional schools so long as the current duration of education at these facilities remain unchanged. It should become a task forces to present a Japanese process model by which therapeutic theories are selected from medical and community models depending on the needs of individual patients or clients, and also to review and rearrange the basic concepts of professional education and post-graduate education at OT education facilities and to present an overall design of a new education system.

There were some limitations in this study that the present analysis of trends did not cover the relationship to other allied health organizations. Objective numerical data on other topics, yielded from this study, are also insufficient. Furthermore, the study has not provided any information on OT in other Asian countries which differ in cultural background from Western countries. In the future, it is desirable to conduct a more comprehensive analysis of various factors, including trends after 2000, and to examine individual problems from diverse angles. It is also desirable to perform comparative analyses of the processes of OT in detail, with the goal of answering the question of how we can define the expertise which can satisfy the social needs under varying cultural backgrounds.

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カナダと日本の作業療法士の臨床・実践と教育システムの動向（1982－2001）

二木　淑子，能登　　真，生田　宗博

要　　旨

本研究は日本とカナダにおける作業療法士の専門職としての動向を，２国の作業療法協会誌に掲載されたの職域・実践や教育の動向に関する論文，キーワードから調査したものである。日本の作業療法士は欧米の影響を強く受けてきており，多くの作業療法士は医学モデルから現状の実践に適した枠組みに移るべき時が来たのではないかと考え始めている。カナダでは作業療法士は社会的変化に対応して既に実践モデルを変化させている。日本では保健・介護システム変革に伴い，作業療法士数は急増し，新しいシステムにあわせて従来の医学モデルを発展させようとしている。医療保健領域におけるパラダイム変化が進む中，両国の文化背景の違いを理解しつつ新しい知識を協同して積み上げていくべきであろう。