**Re-orienting occupational therapy: embracing generative disruption and revisiting a posture that acknowledges human dignity**

**Keywords: covid-19; occupational therapy; occupational justice; human dignity; generative disruption**

**Abstract**

**Introduction:**

Amidst the Covid-19 lockdown that commenced in March 2020, while the profession and service-users were coming to terms with its vast implications, OTASA initiated a Webinar series that stimulated provocative discussions and difficult dialogues. The session on 24 June titled “Ethical and Moral Challenges for Occupational Therapy” was no different, during which competing ethical and moral issues arising from being urged to different ways of thinking and doing occupational therapy from the Covid-19 lockdown, were put forward and reflected upon.

**Method:**

The authors of this paper deliver a commentary, critically engaging with the challenges of articulating cogently the contribution of occupational therapy services across various sectors of service delivery. On the one hand, negotiating the abrupt cessation of rehabilitation services, especially in the public sector and on the other, advancing the reasoning for accessible, community based services.

**Results:**

It is suggested that as we move towards adaptation to uncharted waters of a pandemic, the effects of this pandemic are urging the profession to rethink its positionality in the health sector. Two main considerations deserves attention: The first is rethinking how we use occupational therapy knowledge in order to act from and in relation to local contexts and viewing people who are marginalised as knowledge and action partners through generative disruption. The second is to revisit what a posture that acknowledges human dignity entails.

**Conclusion:**

Generative disruption includes a continuous and unabashed critical reflection of and on the limits of our practice and knowledge at hand. It means that we need to include service users and community partners in taking the necessary steps to render services in local contexts most needed in recalibration toward social and occupational justice. In our knowledge-making partnerships, it is also imperative to revisit the posture of acknowledging human dignity.

**Introduction**

During OTASA’S recent online webinar series, the June 2020 session on “COVID 19: Ethical and Moral challenges for Occupational Therapy” presented a moment for reflexivity where the many competing and urgent moral demands foregrounded by the Covid-19 pandemic could be considered. In the presentation at this webinar, the co-authors invited rethinking of traditional use of knowledge in the profession and embracing an openness to different ways of knowing in occupational therapy so that we start to take action from our local contexts, with marginalized people as knowledge and action partners and be ready to articulate why and how occupational therapy operates best within the context of community based practices. The robust discussion that ensued following the panel of presentations illustrated a need to channel the sense of urgency for more accessible and relevant occupational therapy services to be available to marginalized communities as well as the importance of revisiting what it means to practise human dignity.

**Framing the need for human dignity, accessible and equitable services: Magnified injustices along societal fault lines**

Though before COVID-19, there was an awareness that we live in a context where equity and justice is not experienced in the everyday lives of black people in South Africa and elsewhere, COVID-19 brought into plain view the burden of the humanitarian crisis that marginalized and oppressed people the world-over endure. Internationally the killing of George Floyd has led to renewed attention to the calls for anti-racism as emanating from the Black Lives Matter movement. Likewise in South Africa we’ve seen the fatal consequences of police brutality on people such as Collins Khosa1 on his property, Robin Montsumy while in custody2 and the ruthless shooting of Nathaniel Julies, a teenager with Down syndrome3. This together with the disrespect for human dignity and wellbeing shown for the daily struggles faced by marginalized communities during the initial lockdown and later the peak of the pandemic in South Africa has been evident in the evictions of shack dwellers across the country4-6; the approach to dealing with the needs of people living on the streets7; the continuous inept handling of the pervasive prevalence of Gender-based Violence (GBV)8; the inequality occurring as schools re-open9; the impact of unemployment on food security and lack of access to water at a time when this is needed to preserve life and wellbeing10 – all compounded by increasingly emerging public evidence of widespread corruption and exploitation of relief-funds. At the front of healthcare in a time of crisis, the occupational therapy profession too was again confronted with the limits of its practice, if not its difficulty to articulate collectively the profession’s value and purpose within the rationale of a medical model. At most public hospitals, outpatient rehabilitation services ceased and the turnaround times for admission and discharge of acute-care patients, rendered occupational therapy services moot. The call for the occupational therapy profession to contribute to opposing these issues that not only affect people’s health and wellbeing but often leads to stress, health conditions and disabilities of various forms is embedded in a justice and socially transformative orientation to occupational therapy11. Redesigning occupational therapy services to become more contextually relevant through re-orientating these services and making them accessible to and in community settings is pivotal to this discourse.

**Towards human dignity and accessible, equitable services**

A posture of acknowledging a person’s human dignity is fundamental to contextually relevant services. This posture toward acknowledging a person’s human dignity can be recognized in several ways. One is to inherently regard any person we encounter as an equal and legitimate carrier, and giver of knowledge12-14, therefore recognizing the person’s epistemic virtue. Ndlovu Gatsheni15 states that one form of dehumanization is when one rejects a person’s epistemic virtue, meaning that one can often, sometimes in quite unsaid and tacit ways, render another person as either having no knowledge, or knowledge of a lesser value16. For example, service users of occupational therapy services, may not have the same knowledge as occupational therapists, and yet may have crucial knowledge that needs to be communicated about in to order to deliver effective and relevant services. A second manner in which posture that acknowledges human dignity can be recognized, is to maintain an ego-state from one adult-to-another when we communicate with adult service users. That means that the priority should be to steer clear of adopting communicative ways that assume a paternalistic posture, especially when a person speaks a language that is different to that of the professional; is elderly, has less formal education, or is a person with a disability. Regarding a person as an equal adult and not as a quasi-child, is imperative when we engage in reasoning and knowledge exchange. A third way of maintaining a posture that acknowledges human dignity is to include all relevant stakeholders in decision-making. This may imply that decision-making is often a process, and requires of one to keep asking questions, and to be comfortable with the fact that one, as an occupational therapist, does not know or has to know everything. Moreover, we need to be careful of assuming that we know best at all times for service users, as this masks another form of paternalism16, p. 210, 288 .

Re-orientation and redesign of occupational therapy will be emboldened through collaborating with community health workers and community members while focusing on systemic issues. Some of the lessons learnt during the peak of the Covid-19 pandemic highlights the need to respond to this moral responsibility to contribute to community-driven strategies that reduce poverty and inequality and challenge the systems that maintain inequities. Such approaches supports and extends on the work already happening in communities. While there may be many individual, even personal actions taken to respond to people’s needs, there is also the opportunity to galvanize our actions by critically reflecting on the gaps and approaches to services so that we provide more accessible services. This is supported by the expectation that as health professionals we focus on the social determinants of health11 as guided by the marginalized people in the contexts where we envisage our practice. This could assist in taking action from where we are and based on the ways that we may change what we do as health professionals. Scholarship in occupational science and occupational therapy is available and offers some ideas on the necessary shifts so that the discipline of occupational science and profession of occupational therapy may respond more cogently to the global and local economic, social and political factors that contribute to occupational injustice by limiting human engagement in occupations. Responding through service provision to occupational injustice is implicit in OTASA’s submission to the Truth and Reconciliation Commission in 199717 and more recently the associations expression of our collective commitment to standing in solidarity in ending systemic racism and forms of oppression18, p.19. To illustrate what taking action from where you think and do from could look like, we offer demonstrate a contribution from academia during the lockdown.

**Challenging the status quo through generative disruption**

The first author, as part of a research group with colleagues and disability advocates in Inclusive Practices Africa, urged the Presidency and with the Department for Women, Youth and Persons with Disabilities and the Department of Social Development to motivate for mainstreaming disability inclusion into planning of covid-19 responses. We proposed that resources should be mobilized to support persons with disabilities, their families and communities in multiple ways. Through a series of implementation practices, for example, advocacy meetings with key decision-makers and communicating key messages of how disability intersects with societal issues such as Gender-Based Violence, we saw some inclusion of disability in the languaging of planning for Covid-19 in the presidency and various departments. This even became evident in the president’s third addresses to the nation where he identified the specific needs of persons with disabilities more explicitly. While this advocacy made a small contribution, adding to the voices of the many Non-profit organisations and Persons with Disabilities already advocating, much more needs to be done, especially with regards to implementation of accessible services. Health and rehabilitation professionals could be more available to contribute at district levels, re-directing services from acute and tertiary care, towards communities. This is especially true when realizing that occupational therapy services were less relevant in acute settings during Covid-19 as the turnaround time between admission and discharge did not allow for rehabilitation. Also, for people accessing services in the private sector, more services that connect with their home environments and supports are needed. We cannot afford to be silent or absent from creating disability inclusive services, unfortunately we know what the consequences of the poor state of service provision has been for people with disabilities on the margins, as evidenced in the case of Life Esidimeni19.

While the OTASA TRC submission in 1997 acknowledged the “professions preference to not be involved in politics” 20, the current OTASA statement signals that this preference together with trying to be neutral and silent, for that matter, in the face of inequity and oppression is intolerable. Implicit to this is the need to de-link from the systems of thinking that holds us captive to complying with bio-medially oriented systems and systems that marginalize groups of people11, 21, 22. This concept of de-linking has been identified as being a part of generative disruption and draws from the decolonial scholarship of Walter Mignolo who writes that de-linking from coloniality is an ideological and a pragmatic project23, 24. As such, generative disruption involves the profession continuously questioning where it is that we think from so that we ensure that we shift to thinking from a place where we utilize or seek knowledges that allows us to take actions that promote equity and justice. In essence, this means challenging systemic and interpersonal oppression as it occurs in our everyday occupations so that taken-for-granted hegemonies related to race, ableism, gender or similar discriminatory practices are questioned. We will be able to shift our practices to do this through critical reflexivity on *how privilege and oppression operates through what is known***,** through how we are see one another as beings and through what we do in the contexts that we find ourselves in. Such critical reflexivity is emboldened when we focus on the (occupational) contexts where people live. So while occupational therapists may be called upon to assist in acute care during Covid-19, we can also look to serve the many people who will not access hospital-based care. Many Community Health Workers, volunteers and people in communities need support and guidance to assist with designing solutions and accessing resources as they face the everyday burdens of social inequality, occupational and epistemic injustice. It is here that occupational therapists could be useful resource persons, being available to communities during this time. While we do this we can also learn how to change our practice in the long-term to respond to the needs as we come to understand them more. The Occupation based Community Development framework provides some guidance on how to engage in change processes in ways that respects how the histories of marginalized people has been shaped by dominating geo-political, economic and social factors25 and how these factors influence occupational engagement during covid-19. Through doing praxis that uses participatory action learning methodologies and decolonial perspectives, we can generate questions that will fuel our practice. Our work now is to open up possibilities for more equitable spaces of action to emerge. While there are many possibilities for how to do this, two examples are: Occupational therapists could be available through existing governmental call centres to provide advice for people calling in for advice on Gender-Based Violence, also offering specialized guidance to Persons with Disabilities and their caregivers. Occupational therapists could also be available as resource persons at district levels to MHSUs, their families and communities who are trying to assist MHSUs in their communities. Of course, if we redeployed some of our services from tertiary levels of care to district levels, it would mean that services would be much more accessible and this together with redesigning services so that we include a focus in justice would position the profession well to serve during and post the covid-19 pandemic. Furthermore, if at district levels we shifted from focusing on clinical services, there are many possibilities for how to re-imagine practice.

**Conclusion**

Embracing generative disruption is about being open to not knowing and learning to know through collaborating with marginalized people. This means that we will need to become accepting of not always having solutions at the outset and instead rethink and co-design our services so that we collaborate with people who are oppressed and marginalized. Revisiting the posture of acknowledging and *practising* human dignity means that we need to consciously interrogate the extent to which we unconditionally accept a person’s inherent epistemic virtue; view service users as legitimate bearers and sharers of knowledge; interact from one adult to another in our knowledge-exchanges, and include service users in what is often a *process* of decision-making. In this moment of and post-Covid-19 we need to seize the chance to practice in ways that support participation in occupations more equitably. It means using our expertise in service in ways that respond to people’s needs in contexts. We can do this by working with organisations and movements already active, such as the C-19 peoples coalition, people we can partner with and learn from.

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