Underrepresented Minority Recruitment: Manpower as Motivator in Late Twentieth-Century Occupational Therapy and Physical Therapy

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SUMMARY: This article offers a historical perspective on diversity, equity, and inclusion initiatives in health professions. Historians have highlighted how workforce shortages have facilitated increased gender diversity in male-dominated scientific and clinical occupations. Less attention has been given to manpower as a motivator for enhancing racial/ethnic diversity. I explore the history of minority recruitment, retention, and inclusion initiatives in occupational therapy and physical therapy after 1970 and examine the evolving ways in which the longstanding underrepresentation of racial/ethnic minority health professions students and practitioners was recognized, mobilized, and instrumentalized in each field. I argue that broad-based manpower concerns, though often compelling initial motivators for action, were insufficient for sustaining successful and long-term minority initiatives, due to constant shifts in job market demand. Instead, this article shows that annual and institutionalized minority-specific awards and fundraisers were the most effective strategies for maintaining minority recruitment initiatives over multiple decades.

KEYWORDS: minority recruitment, manpower, workforce concerns, diversity, equity, inclusion, professional newsletters, occupational therapy, physical therapy, medicine, allied health, health education

The author thanks Gini Blodgett Birchett and the American Physical Therapy Association for providing access to numerous valuable sources; Lynn Schneiderman for extensive interlibrary loan services; the National Science Foundation (#1655013), Creighton University, and the Fr. Henry W. Casper, SJ Professorship in History for financial support; Molly Whitlow, Kristine Au, and Mark Nguyen for their engagement and assistance in this research; Sabrina Danielsen and three anonymous peer-reviewers for their valuable feedback and advice.

In 1989, the Institute of Medicine (IOM), an American health policy organization, published *Allied Health Services: Avoiding Crises.* The report was initiated by a Congressional mandate to study the current status of allied health fields—occupations that work closely with or under the direction of physicians. Among their findings, the authors identified a few allied health fields, including the rehabilitation specialties of occupational therapy (OT) and physical therapy (PT), that were likely to experience severe shortages in available workers over the coming decade. Looking to demographic trends, the authors noted that fewer college-aged students and a growing population of older Americans needing rehabilitation were major drivers of workforce imbalances. In light of these trends, they suggested strategies for preventing personnel crises.[1]

The IOM report focused its analyses on avoiding *future* crises. In doing so, it overlooked a serious and longstanding crisis in nearly all U.S. health professions—the severe and persistent shortage of racial/ethnic minority students and practitioners. This ongoing crisis involved a lack of healthcare access, practitioner-patient concordance, and health career opportunities for many racial/ethnic minority communities.[2] The authors were aware of these issues, but instead of viewing the disproportionately low representation of minority clinicians as an independent and endemic *problem* in health professions education, they presented this situation as an *opportunity* to address manpower shortages—*before* a broader workforce crisis emerged. As the IOM report's authors put it, "minorities represent a relatively untapped source of manpower." They encouraged allied health training programs that were struggling to recruit enough applicants to consider "less traditional applicant pools" and, foremost among them, racial/ethnic minorities.[3]

1. Institute of Medicine, *Allied Health Services: Avoiding Crises* (Washington, D.C.: National Academies Press, 1989).

2. John O. Brown, "Crisis in Health Care for Black Americans." *J. Nat. Med. Assoc.* 79, no. 3 (1987): 260–62; Ruth S. Hanft and Catherine C. White, "Constraining the Supply of Physicians: Effects on Black Physicians." *Milbank Quart.* 65, no. 2 (1987): 249–69; Leonard E. Lawrence, "A Crisis in Medical Education." *J. Nat. Med. Assoc.* 85, no. 12 (1993): 902–4; Lisa Cooper-Patrick et al., "Race, Gender, and Partnership in the Patient-Physician Relationship." *JAMA* 282, no. 6 (1999): 583–89; Alondra Nelson, *Body and Soul: The Black Panther Party and the Fight Against Medical Discrimination* (Minneapolis: University of Minnesota Press, 2011); Ayah Nuriddin,"Psychiatric Jim Crow: Desegregation at the Crownsville State Hospital, 1948–1970." *J. Hist. Med. & Allied Sci.* 74, no. 1 (2019): 85–106; Brad N. Greenwood et al., "Physician–Patient Racial Concordance and Disparities in Birthing Mortality for Newborns." *PNAS* 117, no. 35 (2020): 21194–200.

3. Institute of Medicine, *Allied Health Services* (n. 1), 7.

This article examines the evolving ways in which the longstanding underrepresentation of racial/ethnic minority healthcare students and practitioners has been recognized, mobilized, and instrumentalized in the American fields of OT and PT. Over the past decade, numerous academic and health professions have newly recognized and sought to address the lack of representative racial/ethnic diversity among their students and practitioners. These initiatives follow earlier periods, since the late 1960s, of increased emphasis on the recruitment, retention, and inclusion of underrepresented racial/ethnic minorities in clinical fields—the lessons of which have been largely overlooked amidst present efforts. As activists seek to make the most of current increased attention to race-based injustices, there is much to be learned from the motives, successes, shortcomings, and barriers to previous diversity, equity, and inclusion campaigns.[4]

OT and PT are clinical rehabilitation fields that have similar histories, practitioner demographics, and roles within the hierarchy of clinical practice.[5] Each occupation has always been primarily white and female, with practitioners from racial/ethnic minority backgrounds significantly underrepresented.[6] Notably, the trajectory of efforts in OT and PT to enhance minority recruitment have been quite distinctive—reflecting the range of motivators for, and barriers against, these initiatives in health professional fields. Whereas the American Physical Therapy Association's (APTA) approaches, beginning in the early 1970s, were slow, steady, and institutionalized, the American Occupational Therapy Association's (AOTA) efforts were late-coming and intensive during the 1990s, but ultimately tenuous and short lived. This variance was influenced by differences in the leadership and concerns of each field, as well as their finan-

4. Marc A. Nivet, "Commentary: Diversity 3.0: A Necessary Systems Upgrade." *Acad. Med.* 86, no. 12 (2011): 1487–89; Michael Mascarenhas, "White Space and Dark Matter: Prying Open the Black Box of STS." *Sci., Technol. & Hum. Val.* 43, no. 2 (2018): 151–70; Projit B. Mukharji et al., "A Roundtable Discussion on Collecting Demographics Data." *Isis* 111, no. 2 (2020): 310–53; Stacy Wilson et al., "Occupational Therapy's Commitment to Diversity, Equity, and Inclusion." *Amer. J. Occup. Therapy* 74, supp. 3 (2020): 7413410030p1; Ndidiamaka D. Matthews et al., "Beyond a Statement of Support: Changing the Culture of Equity, Diversity, and Inclusion in Physical Therapy." *Phys. Therapy* 101, no. 12 (2021): https://doi.org/10.1093/ptj/pzab212.

5. Institute of Medicine, *Allied Health Services* (n. 1), 29–34; Glenn Gritzer and Arnold Arluke, *The Making of Rehabilitation: A Political Economy of Medical Specialization, 1890–1980* (Berkeley: University of California Press, 1985), 123–44.

6. Roxie M. Black, "Occupational Therapy's Dance with Diversity," *Amer. J. Occup. Therap.* 56, no. 2 (2002): 140–48; Angela Byars-Winston, Nadya Fouad, and Yao Wen, "Race/ethnicity and Sex in US Occupations, 1970–2010: Implications for Research, Practice, and Policy." *J. Vocational Behav.* 87, no. 4 (2015): 54–70.

cial stability in the U.S. healthcare marketplace—as it was being actively reshaped during this period.

As majority female professions, OT and PT had much in common with nursing and many other medicine-adjacent fields. These practitioners often engaged in the emotional labor and bodywork that medicine and other male-dominated professions eschewed and assigned to them.[7] During and after World War II, as demand for their services increased, OTs and PTs increasingly delegated routine clinical tasks to their own specially trained aides and technical assistants. Notably, though PT and OT assistants were somewhat more racially/ethnically diverse than their professional counterparts, as a population, they were also disproportionately white and female.[8]

Late twentieth-century minority recruitment, retention, and inclusion initiatives in health professions most often targeted racial/ethnic groups that were underrepresented in medicine and other clinical fields, relative to their numbers in the U.S. population—specifically Black, Latinx, and Indigenous Americans. Asian Americans were often excluded from these initiatives, due to perceptions of overrepresentation in health professions—even though Asian American students, clinicians, and patients also experienced significant discrimination.[9] Much of the advocacy and efforts that I highlight in this article primarily focused on increasing the

7. Gritzer and Arluke, *The Making of Rehabilitation* (n. 5); Margarete Sandelowski, *Devices and Desires: Gender, Technology, and American Nursing* (Chapel Hill: University of North Carolina Press, 2000); Beth Linker, "Strength and Science: Gender, Physiotherapy, and Medicine in the United States, 1918–35," *J. Women's Hist.* 17, no. 3 (2005): 106–32; Mary E. Fissell, "Introduction: Women, Health, and Healing in Early Modern Europe," *Bull. Hist. Med.* 82, no. 1 (2008): 1–17; Patricia D'Antonio, *American Nursing: A History of Knowledge, Authority, and the Meaning of Work* (Baltimore: Johns Hopkins University Press, 2010).

8. Darrel J. Mase, "Manpower Utilization for the Future," *J. Rehabil.* 30, no. 1 (1964): 37–62; Nancy T. Watts, "Task Analysis and Division of Responsibility in Physical Therapy," *Phys. Therap.* 51, no. 1 (1971): 23–35; Rita P. Fleming Cottrell, "COTA Education and Professional Development: A Historical Review," *Amer. J. Occup. Therapy* 54, no. 4 (2000): 407–12; AOTA, *Annual Programs Data Report: Academic Year 2020–2021* (North Bethesda, Md.: AOTA, 2022); Commission on Accreditation in Physical Therapy Education, *Aggregate Program Data: 2021 Physical Therapist and Physical Therapist Assistant Education Programs Fact Sheets* (Alexandria, Va.: CAPTE, 2023).

9. Charles E. Odegaard, *Minorities in Medicine: From Receptive Passivity to Positive Action, 1966–76* (New York: Josiah Macy Jr. Foundation, 1977); American Association of Medical Colleges, "Underrepresented in Medicine Definition," (2004) https://www.aamc.org/what-we-do/equity-diversity-inclusion/underrepresented-in-medicine (Accessed May 26, 2022); Corinna J. Yu, "Asian Americans: The Overrepresented Minority? Dispelling the 'Model Minority' Myth." *ASA Monitor* 84, no. 7 (2020): 32–33.

representation of Black practitioners, who until the 1990s were part of America's largest racial/ethnic minority group.

Various factors led health professions to invest in minority recruitment, retention, and inclusion efforts during the late twentieth century. These included broader sociopolitical trends, such as the Civil Rights Movement and awareness of America's growing racial/ethnic diversity; the desire to mirror the activities of medicine and other more prestigious professions; and advocacy from within each occupation to invest in minority initiatives. Another compelling motivator was concern about general manpower shortages. Between the 1970s and 1990s, the OT and PT fields experienced ever-increasing demand for their services and struggled to produce enough new practitioners to fill the growing number of open positions in hospitals and other care settings. While strong demand meant plentiful job opportunities and higher salaries, AOTA and APTA feared that chronically unfilled positions would be permanently lost to other occupations, leading to a weakened status for their profession in the healthcare marketplace.[10]

Concerns about, and assessments of, workforce shortages in OT and PT generally focused on national level statistics. Actual manpower deficits varied by region, locality, and work setting. While leaders in AOTA and APTA certainly recognized the underrepresentation of racial/ethnic minorities among their field's practitioners, manpower initiatives were primarily driven by perceptions of broad-based shortages, rather than specific disparities. OTs and PTs from minority backgrounds were much more acutely aware of the true impacts of racial/ethnic practitioner underrepresentation. These shortages affected the availability and quality of care and led minority students and practitioners to feel like outsiders in their own field.[11] Throughout this article, I highlight the important roles of Black therapists in promoting and leading minority initiatives. These OTs and PTs took strategic advantage of broad-based workforce concerns to help justify targeted investments in minority recruitment. In doing so, they hoped that their profession's responses to general manpower short-

10. Gladys Masagatani et al., *Occupational Therapy Manpower: A Plan for Progress* (Rockville, Md.: American Occupational Therapy Association, 1985), 44; Marilyn Moffat, "President's Perspective: Shortages Abound!" *Prog. Rep.* 20, no. 10 (1991): 3.

11. Institute of Medicine, *Allied Health Services* (n. 1); Masagatani et al., *Occupational Therapy Manpower* (n. 10); Moffat, "President's Perspective" (n. 10); Lou Robinson, *The Black Occupational Therapy Caucus: The First 25 Years, 1974–1999* (Bridgeton, Mo.: Black Occupational Therapy Caucus, 2000); Keshrie Naidoo, "Networked Mentoring to Promote Social Belonging among Minority Doctor of Physical Therapy Students" (Ph.D. diss., Johns Hopkins University, 2020).

ages would lead to long-lasting minority initiatives. Unfortunately, these efforts did not always outlast job market downturns.

Historians have previously described instances in which perceived workforce shortages in scientific and medical areas have led homogeneous fields to grow more diverse. The opening of dozens of new medical schools during the 1960s and 70s, due to concerns about severe physician shortages, facilitated a rise in the number female medical students.[12] Parallel anxieties in nursing led to the recruitment and exploitation of Filipino nurses to address post-WWII workforce shortages.[13] Around the same time, Cold War era considerations resulted in efforts to train more women in the sciences. Government reports during the late 1950s showed the extent to which the United States was missing out on its own highly capable "womanpower," of which the Soviet Union was taking full advantage. As Margaret Rossiter has shown, these concerns led to the encouragement of many more women to pursue science PhDs during the 1960s, only to graduate into a tight job market in the early 1970s—after government investments in basic science and defense-related research declined.[14] Indeed, while acute workforce demands can be a powerful initial impetus for increasing the diversity of professional recruitment, these concerns—and the initiatives developed from them—are often short-lived and highly contingent on external factors.

Scholars have done little to consider how workforce demands influenced initiatives to increase the racial/ethnic diversity of health professions fields.[15] As with efforts to increase "scientific womanpower," many

12. Ellen S. More, "The American Medical Women's Association and the Role of the Woman Physician, 1915–1990," *J. Amer. Med. Women's Assoc.* 45, no. 5 (1990): 165–80; Ellen S. More, *Restoring the Balance: Women Physicians and the Profession of Medicine, 1850–1995* (Cambridge, Mass.: Harvard University Press, 2001), 192–93.

13. Catherine Ceniza Choy, *Empire of Care: Nursing and Migration in Filipino American History* (Durham, N.C.: Duke University Press, 2003).

14. Laura Micheletti Puaca, *Searching for Scientific Womanpower: Technocratic Feminism and the Politics of National Security, 1940–1980* (Chapel Hill: University of North Carolina Press, 2014), 43–84; Margaret W. Rossiter, *Women Scientists in America: Before Affirmative Action, 1940–1972* (Baltimore: Johns Hopkins University Press, 1995), 361–76.

15. Choy, *Empire of Care* (n. 13); On related topics: Charles D. Chamberlain, *Victory At Home: Manpower and Race in the American South During World War II* (Athens: University of Georgia Press, 2003); Russell B. Olwell, *At Work in the Atomic City: A Labor and Social History of Oak Ridge, Tennessee* (Knoxville: University of Tennessee Press, 2004), 20–24, 74–77; Ellen S. More, Elizabeth Fee, and Manon Parry, *Women Physicians and the Cultures of Medicine* (Baltimore: Johns Hopkins University Press, 2009); Amy E. Slaton, *Race, Rigor, and Selectivity in U.S. Engineering: The History of an Occupational Color Line* (Cambridge, Mass.: Harvard University Press, 2010); LaGuana Gray, *We Just Keep Running the Line: Black Southern Women and the Poultry Processing Industry* (Baton Rouge: Louisiana State University Press, 2014);

late twentieth-century clinical professional organizations—faced with significant workforce demand and declining student enrollments—began looking to historically underrepresented populations to help fill their training programs and meet their personnel needs.[16] In this article, I argue that broad-based manpower concerns in health professions, even when they were compelling initial motivators to act, proved insufficient to sustain successful and long term minority initiatives—due to constant shifts in job market demand. Based on my comparison of late twentieth-century OT and PT, I show that the establishment of annual and institutionalized minority-specific awards and fundraisers were the most effective strategies for maintaining recruitment initiatives over multiple decades.

The underrepresentation of racial/ethnic minority students and practitioners in health fields is the product of historical and ongoing systemic discrimination and exclusion—by professions themselves, as well as broader structural inequities in education, opportunities, and resources.[17] Ultimately, these obstacles can only be productively addressed through long-lasting and unwavering investments that are not subject to inevitable job market downturns.[18] This article does not intend to explain why OT and PT failed to achieve representative racial/ethnic diversity. Instead, I examine the forces that drove the cyclical nature of national-level health professional associations' investments in minority recruitment, retention, and inclusion—through periods of strong commitment, followed by declining interest. As I show, approaches that were more insulated from the effects of economic uncertainty and job market downturns led to

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Dominique A. Tobbell, *Dr. Nurse: Science, Politics and the Transformation of American Nursing* (Chicago: University of Chicago Press, 2022).

16. Institute of Medicine, *Allied Health Services* (n. 1).

17. "Reflections on the Conference," *Prog. Rep.* 20, no. 2 (1991): 1; Kenneth M. Ludmerer, *Time to Heal: American Medical Education From the Turn of the Century to the Era of Managed Care* (Oxford: Oxford University Press, 1999), 254; Nelson, *Body and Soul* (n. 2); Matthew A. Nuciforo, "Minority Applicants to Physical Therapist Education Programs 2010–2012," *Phys. Therapy* 95, no. 1 (2015): 39–50; Catherine Reinis Lucey and Aaron Saguil, "The Consequences of Structural Racism on MCAT Scores and Medical School Admissions: The Past is Prologue," *Acad. Med.* 95, no. 3 (2020): 351–56; Max Jordan Nguemeni Tiako, Eugenia C. South, and Victor Ray, "Medical Schools as Racialized Organizations: A Primer," *Ann. Internal Med.* (2021): https://doi.org/10.7326/M21-0369; Andrew J. Hogan, "Accessibility in Health Professions Education: The Flexner Report and Barriers to Diversity in American Physical Therapy." *Soc. Sci. & Med.* 341 (January 2024): 116519.

18. Kathy Stolle-McAllister et al., "The Meyerhoff Way: How the Meyerhoff Scholarship Program Helps Black Students Succeed in the Sciences," *J. Sci. Educ. Technol.* 20, no. 1 (2011): 5–16; Marybeth Gasman et al., "HBCUs and the Production of Doctors," *AIMS Pub. Health* 4, no. 6 (2017): 579–89.

longer lasting interventions, which are needed to address deeply rooted structural barriers to inclusion.

A Note on Sources

My examination of minority initiatives in OT and PT benefitted significantly from the examination of professional newsletters and magazines. This genre of periodicals flourished in the late twentieth century, but after 2000 many disappeared or moved online. Professional newsletters and magazines provide unique opportunities for historians to explore how professional associations communicated with members, as well as how members expressed their discontent. These periodicals reflected clinical fields' evolving priorities and concerns. As part of this, their format and frequency of publication allowed them to capture present-moment professional activities and debates in ways that peer-reviewed literature did not. Professional newsletters and magazines have recently been disappearing from academic libraries due to weeding practices, budget cuts, and limited space. Much is lost when these periodicals are discarded from the very few collections in which they remain. Historians can help to preserve these sources by more actively using them, as well as by arranging for their digitization.

Race and the Medical Profession in the Twentieth Century

As historians of medicine have long highlighted, a revolution in medical education during the first three decades of the twentieth century helped lead to the systemic exclusion of women and minorities from most medical schools over the next fifty years. Driven by the American Medical Association (AMA) and validated by the Flexner Report (1910), this era's vastly increased standards for prerequisite education, facilities, financial resources, and research in medical schools forced about half to close or consolidate by 1930. Just two historically Black medical schools and one women's medical college survived this period and the remaining white-dominated institutions only sparsely admitted female and racial/ethnic minority students.[19]

19. Gerald E. Markowitz and David K. Rosner, "Doctors in Crisis: A Study of the Use of Medical Education Reform to Establish Modern Professional Elitism in Medicine," *Amer. Quart.* 25, no. 1 (1973): 83–107; Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982), 116–27; Ludmerer, *Time to Heal* (n. 17); "A Half-Century of Progress of Black Students in Medical Schools." *J. Blacks Higher Educ.* 30 (2000/2001): 28–31; Todd Savitt, "Abraham Flexner and the Black Medical Schools." *J. Nat. Med. Assoc.*

Initial efforts to increase minority enrollments in white-dominated medical schools began in the late 1960s, amidst the Civil Rights Movement. Beginning in 1968, many medical schools, which had admitted just one or two Black students per year previously, scaled up their minority admissions. In 1970, AMA and the Association of American Medical Colleges (AAMC) agreed to the goal of increasing racial/ethnic minority student admissions to 12% by 1975. At this time, over 97% of American physicians were white. While this proved to be an overambitious goal, significant progress was made, with minority enrollments topping out at close to 10% in 1975. After this, however, minority student admissions to medical schools remained flat, holding at between 8 and 9% for the next fifteen years—even as the U.S. population grew increasingly diverse.[20]

Various factors affected minority recruitment. In 1974, Allan Bakke, a white man, sued the University of California Davis (UCD) after twice being denied admission by its medical school. Bakke argued that he had been unfairly rejected, because minority students with lower test scores had been admitted. In its decision on Bakke's case, the U.S. Supreme Court prohibited UCD's bipartite approach, which separately considered minority candidates and admitted sixteen from this pool each year.[21] Though the Court did not ban the consideration of race in assessing candidates, it did end the use of UCD's "quota" system, which had proven quite effective in achieving greater racial equity in admissions. AAMC later argued that the *Bakke* decision had a "chilling effect" on affirmative action in medical schools.[22] Along with the *Bakke* decision, emerging concerns in the late 1970s about a potential oversupply of physicians further dampened medical schools' enthusiasm for actively recruiting underrepresented minority students, especially since they could already choose from plenty of academically privileged applicants.[23]

98, no. 9 (2006): 1415–24; Lynn E. Miller and Richard M. Weiss, "Revisiting Black Medical School Extinctions in the Flexner Era," *J. Hist. Med. & Allied Sci.* 67, no. 2 (2012): 217–43.

20. Association of American Medical Colleges, *Report of the AAMC Task Force to the Inter-Association Committee on Expanding Educational Opportunities in Medicine for Blacks and Other Minority Students* (Washington, D.C.: Association of American Medical Colleges, 1970); Odegaard, *Minorities in Medicine* (n. 9), vi, 22; Herbert W. Nickens, Timothy P. Ready, and Robert G. Petersdorf, "Project 3000 By 2000—Racial and Ethnic Diversity in US Medical Schools." *New England J. Med.* 331, no. 7 (1994): 472–76.

21. Ludmerer, *Time to Heal* (n. 17), 253-254; Bernard Schwartz, *Behind Bakke: Affirmative Action and the Supreme Court* (New York: New York University Press, 1988).

22. Nickens, Ready, and Petersdorf, "Project 3000 by 2000" (n. 20), 473.

23. Starr, *Social Transformation* (n. 19), 421–27; Graduate Medical Education National Advisory Committee, *Summary Report* (Washington, D.C.: Department of Health and Human Services, 1980); Eli Ginzberg and Miriam Ostow, *The Coming Physician Surplus: In Search of a*

Following medicine, many other health professional fields eventually introduced their own minority initiatives. A variety of factors influenced how quickly each profession began pursuing these goals. During the late 1960s, the allied health and rehabilitation field of speech-language pathology was already engaged in prominent discussions about how to assess Black English dialects—a topic that led to the American Speech-Language-Hearing Association's early investments in professional minority inclusion activities.[24] In OT and PT, the politics of race were less immediately relevant to practice, and both fields were slower to begin minority initiatives. As I describe in the sections ahead, decisions by AOTA and APTA to pursue and maintain racial/ethnic minority recruitment and inclusion efforts were influenced by individual members, social trends, financial factors, and—to varying degrees—concerns about manpower.

Minority Recruitment Initiatives in Physical Therapy

In 1970, Marilyn Moffat, a PT and editor of APTA's flagship journal *Physical Therapy*, commented on how poorly the PT field was doing in addressing the ongoing crisis of healthcare needs in underserved communities. Part of the problem, she suggested, was that PT education programs were not actively recruiting racial/ethnic minority students. This was a troubling trend, Moffat lamented, especially when the PT profession was also not meeting its broader workforce needs. PT education programs, she suggested, could simultaneously address limited access for underserved populations and broader manpower shortages through minority recruitment.[25]

Moffat's call to action was not ignored. The next year, an article in *Physical Therapy* stated, "The great shortage of qualified personnel in all health fields is sufficient proof of the necessity for encouraging individuals from all ethnic groups to consider physical therapy as a possible

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Policy (Totowa, N.J.: Rowman and Allanheld, 1984); Odegaard, *Minorities in Medicine* (n. 9), 102–14; Ludmerer, *Time to Heal* (n. 17), 253–55.

24. "The Association in a Conflict Society," *ASHA* 11, no. 3 (1969): 92; Orlando L. Taylor, "Social and Political Involvement of the American Speech and Hearing Association," *ASHA* 11, no. 5 (1969): 216–18; John F. Michel, "The Role of ASHA in Social, Political, and Moral Activities," *ASHA* 11, no. 5 (1969): 219–20; ASHA Black Caucus, "Philosophies and Goals of the ASHA Black Caucus," *ASHA* 11, no. 5 (1969): 221–25; Joan C. Baratz, "Language in the Economically Disadvantaged Child: A Perspective," *ASHA* 10, no. 4 (1968): 143–45; Elizabeth Thompson Beckley, "A Perspective-Shaping Convention," *ASHA Leader* (August 1, 2015), https://doi.org/10.1044/leader.FTR1.20082015.42 (accessed May 10, 2022).

25. Marilyn Moffat, "Editor's Note," *Phys. Therap.* 50, no. 3 (1970): 335.

career choice."[26] The recommendations of three Black PTs, two men and one woman, were presented. Leon Anderson, an up and coming leader in APTA, argued, "Until all Americans are afforded equal educational opportunities, seeking out and aiding young black students is a moral obligation. This is particularly true of health professions with manpower shortages."[27] Such efforts addressed both limited minority career opportunities *and* broader workforce issues.

The APTA Board of Directors felt similarly. In 1971, the association established a $500 annual award to recognize a PT education program for efforts to increase minority recruitment. Later that year, Leon Anderson was elected to the Board of Directors—becoming the first Black national office holder in APTA history.[28] Over the coming years, as APTA's leadership prominently honored the minority recruitment activities of PT education programs, some progress was made in increasing racial/ethnic diversity. A 1978 survey found that, while 3.7% of APTA members identified as minorities, that number was 6.5% among recent graduates.[29]

Despite these initial gains however, some expressed disappointment that APTA had not pushed to achieve more. In 1980, Elizabeth McBride, a PT educator, encouraged the association to play a more active role in helping PT education programs to recruit minority students and in supporting minority PTs to become professional mentors and leaders. Harley E. Flack, a Black PT and dean of Howard University's School of Allied Health Sciences, similarly argued that providing more opportunities for minority students to succeed in PT, by making PT education programs less discriminatory, was the "unfinished business of the 1970s."[30] Just as enthusiasm for minority initiatives declined in medicine during the late 1970s, with the *Bakke* decision and concerns about a physician surplus, many PTs felt that APTA's investments were also lagging.

Nonetheless, the Award for Excellence for Minority Recruitment and Service continued to be given out at APTA's national conference. Each

26. "What's the Answer?," *Phys. Therapy* 51, no. 4 (1971): 456–60, 456.

27. Ibid., 459.

28. Fred Rutan, "Board of Directors Midyear Meeting," *Phys. Therapy* 51, no. 6 (1971): 701–7; "APTA HQ Room Named for Visionaries Leon Anderson Jr., Lynda Woodruff," *APTA News*, (August 17, 2021), https://www.apta.org/news/2021/08/17/anderson–woodruff (accessed May 10, 2022).

29. James Clinkingbeard, Jan Toms, and Laura Smyth Brown, "Forum—Education News: Minority Recruitment Activities Up," *Prog. Rep.* 10, no. 5 (1981): 6. (access courtesy of the American Physical Therapy Association).

30. Elizabeth T. McBride, "Increasing Minorities in the Physical Therapy Profession Through Student Admissions," *Phys. Therapy* 60, no. 10 (1980): 1284–88; Harley E. Flack, "Unfinished Business of the 1970s," *Phys. Therapy* 60, no. 10 (1980): 1283.

year, the Committee on Minority Recruitment and Service, which was made up primarily of minority PTs, chose a winner. Notably, during the award's first fifteen years, it was given out to relatively few universities. Multiple PT programs won the award twice and some years no winner was named.[31] It is beyond the scope of this article to examine the minority recruitment and inclusion activities of specific PT and OT programs. However, the limited distribution of APTA's minority recruitment and service awards during the 1970s and 80s suggests that relatively few PT education programs were actively engaged in the activities that the award had been established to encourage.

The Committee on Minority Recruitment and Service also provided consultation to individual PT education programs that were interested in increasing their activities.[32] Minority recruitment efforts in specific programs relied significantly on major investments of faculty time, motivation, and resources. Some of this was made possible by external grants, such as the U.S. Department of Health and Human Services' Health Career Opportunities Program. Such funding though, was often short-lived, and minority programs were scaled down after grants expired.[33]

A number of Minority Recruitment and Service awardees went on to run for the APTA Board of Directors. Undoubtedly, the significant presence of multiple supporters of minority initiatives on the APTA Board during the 1980s helped to ensure continued investments. This included establishing the APTA Advisory Council on Minority Affairs, the Plan to Foster Minority Representation and Participation, and two new minority-specific annual awards in 1983—including one to recognize APTA state chapters' efforts to recruit minority students.[34]

During the mid 1980s, multiple highly influential Black PTs, including Leon Anderson and Lynda Woodruff, led the Advisory Council on Minority Affairs and maintained close relations with the APTA Board of Directors. Anderson and Woodruff played a central role in establishing

31. Clinkingbeard, Toms, and Smyth Brown, "Forum—Education News" (n. 29); "APTA Salutes Outstanding Physical Therapists at San Antonio Ceremony," *Prog. Rep.* 16, no. 7 (1987): 14.

32. Clinkingbeard, Toms, and Smyth Brown, "Forum—Education News" (n. 29); Fred Rutan, "Postconference Board of Directors Meeting," *Phys. Therap.* 52, no. 11 (1972): 1169–72; Fred Rutan, "Preconference Board of Directors Meeting," *Phys. Therap.* 53, no. 11 (1973): 1173–78.

33. Awilda R. Haskins, "Recruitment of Minorities into the Health Professions," *J. Phys. Therapy Educ.* 3, no. 2 (1989): 14–17.

34. "APTA Officers, Directors, and Committees," *Phys. Therap.* 62, no. 11 (1982): 1632–34; "Board Adopts Plan on Minorities," *Prog. Rep.* 13, no. 1 (1984): 6. (access courtesy of the American Physical Therapy Association.)

annual scholarships for minority PT students, beginning in 1988. Along with multiple minority-specific APTA awards that recognized students and faculty, these scholarships continued to be given out annually in the 2020s.[35] By the early 1990s, five $2000 scholarships were awarded each year to minority PT students. In 1993, an annual gala was established as a fundraiser for minority scholarships. It also continued to be held three decades later.[36]

In another major step, during the late 1980s, APTA established the Office of Minority Affairs, which helped to manage minority recruitment materials and efforts, as well as collect nominations for the association's three annual minority-specific awards. Johnette Meadows, a Black PT, was hired to direct the office in 1988. She remained in this position for more than three decades.[37] The many activities of the Advisory Council on Minority Affairs and Office of Minority Affairs were regularly highlighted for APTA's membership in the association's professional interest and news periodicals, *Progress Report* and *PT Magazine*.[38] For historians today, these periodicals provide clear evidence that, throughout the late twentieth century, APTA made prominent, institutionalized, and recurring investments in minority recruitment, retention, and inclusion. APTA's efforts in this area were relatively low-cost, especially since targeted fundraising was used to support minority scholarships. Importantly, APTA's commitments were enduring—surviving periods of evolving professional and financial concerns in the association.

As minority recruitment efforts grew, association leaders continued to stress the need to address ongoing manpower shortages. In 1991, Moffat, by then president of APTA, highlighted PT's severe workforce shortages

35. "APTA HQ Room," (n. 28).

36. Beth Monahan, "Reaching Out for a More Diverse Profession," *PT Mag.* (February 1994): 34–45; PT Fund Celebration of Diversity, February 3, 2022, https://www.apta.org/celebration-of-diversity (accessed May 10, 2022).

37. "May We Introduce . . . Minority Affairs," *Prog. Rep.* 16, no. 9 (1987): 11; Thomas E. Simonton, "Meadows Directing Minority Affairs," *Prog. Rep.* 18, no. 1 (1989): 5; "APTA Continues Strategic Investments to Support Diversity, Equity, and Inclusion," *APTA News* (May 8, 2020), https://www.apta.org/news/2020/05/08/apta-continues-strategic-investments-to-support-diversity-equity-and-inclusion (accessed on May 10, 2022).

38. Clinkingbeard, Toms, and Smyth Brown, "Forum—Education News," (n. 29); "May We Introduce," (n. 37); Monahan, "Reaching Out" (n. 36); "Association Sets Plans for 1983," *Prog. Rep.* 12, no. 1 (1983): 6–8 (access courtesy of the American Physical Therapy Association); "APTA Annual Report 1986," *Prog. Rep.* 16, no. 5 (1987): 1 (insert); Tommye Morton, "APTA Board Forms Ad-Hoc Committee," *Prog. Rep.* 16, no. 8 (1987): 14; "APTA Affirmative Action Policy in High Gear; Members Encouraged to Climb Aboard," *Prog. Rep.* 16, no. 10 (1987): 11; "An APTA Goal: Increasing the Role of Minorities," *Prog. Rep.* 17, no. 8 (1988): 13; "Diversity 2000 Raises More Than $40,000," *Prog. Rep.* 3, no. 11 (1995): 110.

and warned members of the potential impacts. She argued, "if we do not face the personnel requirements for physical therapy aggressively and from all perspectives, we should and must expect the gaps to be occupied by other professions."[39] Open positions that were left unfilled by PTs were likely to be permanently lost to the field. Indeed, just this was happening at the Veterans' Administration, where kinesiotherapists—practitioners who were trained onsite, rather than in academic programs—had taken over many of the VA's budgeted PT positions. This was largely because PTs could earn more elsewhere.[40]

While Moffat and Anderson had initially mobilized workforce shortages as a motivator for improving racial/ethnic minority recruitment in the early 1970s, during subsequent decades these two pursuits became largely decoupled. In fact, enhancing minority recruitment was not a viable strategy for increasing manpower in PT. The field's education programs had many more applicants than available spots and were consistently filled to capacity. Thus, the major barrier to increasing the PT workforce was not attracting more potential students, but rather opening new training programs, expanding class sizes, and retaining existing PTs.[41] At the same time, by the late 1980s, APTA's investments in minority recruitment and inclusion initiatives were well established and had significant support and momentum. Although workforce shortages had been an initial justification for these efforts, they had become an independent and enduring priority.

Interlude: PT and OT in Historical Context

The trajectory of minority recruitment initiatives in OT and PT were shaped by the broader histories of each field. Historians of medicine have not thoroughly examined these histories, especially after World War II. Beth Linker has described the significance of early twentieth-century PT in providing a chance for educated women to escape the Victorian era's strict gender expectations. In most female-dominated health professions, like nursing, women were limited to caring and empathetic

39. Moffat, "President's Perspective: Shortages Abound!" (n. 10).

40. Bob Downes, "It's Come a Long Way, But Recruitment Problems Still Plague the VA," *PT Bull.* 5, no. 5 (1990): 62–64; Ellen Strickland, "Trouble With KTs," *PT Bull.* 5, no. 8 (1990): 8.

41. Moffat, "President's Perspective: Shortages Abound!," (n. 11); "Reflections on the Conference," (n. 17); Marilyn Moffat, "President's Perspective: Staying With the Profession." *Prog. Rep.* 21, no. 9 (1992): 3, 14; Jules M. Rothstein, "Editor's Note: Proliferation of Schools," *Phys. Therapy* 74, no. 6 (1994): 518–20.

roles. However, as PTs, women provided physical—and sometimes pain inducing—interventions, which required physical strength. This evasion of traditional gender roles was made possible by the needs of World War I, for competent personnel to participate in the physical rehabilitation of soldiers. The war context gave women the chance to establish PT as a medically respected specialty and a scientifically oriented profession.[42]

The initial growth of OT was also closely related to World War I rehabilitation needs. However, OTs had distinct origins and practices. The founders of OT were a mix of men and women from a variety of professional backgrounds, including medicine, psychiatry, social work, handcrafts, and women's social movements during the Progressive Era. OTs worked to help rehabilitate soldiers, often in psychiatric settings, by helping to occupy their minds and their hands as they convalesced. While early PTs sought to explicitly align their profession as a branch of, and contributor to, scientific medicine, OTs were critical of medicine's narrowly biological focus. They pursued a broader, more psychosocial epistemology and problem orientation.[43]

During the interwar period, OTs and PTs desired greater autonomy, but realized that their professional survival was tethered to medicine's recognition. APTA negotiated this landscape by positioning the PT field as a reliable ally and contributor to mainstream, post–Flexner Report scientific medicine. PTs successfully carved out a distinct niche for themselves as independent practitioners who always worked under the direction of physicians, though often at a distance.[44] Along similar lines, AOTA created its own standards for training, but turned to AMA to help accredit OT education programs.[45] The rehabilitation needs of World War II would eventually add to the growth of OT and PT, but wartime and postwar bureaucracy also posed additional challenges to autonomy. During this period, each field felt forced to accept stronger epistemic

42. Linker, "Strength and Science" (n. 7); Beth Linker, *War's Waste: Rehabilitation in World War I America* (Chicago: University of Chicago Press, 2011), 70–78; Bess Williamson, "Physical Therapy, Design, and Technology in a Changing World," *Phys. Therapy* 101 (2021): https://doi.org/10.1093/ptj/pzab220.

43. Virginia A. Mexatas Quiroga, *Occupational Therapy: The First 30 Years, 1900–1930* (Washington, D.C.: American Occupational Therapy Association, 1995); Lori T. Anderson and Kathlyn L. Reed, *The History of Occupational Therapy: The First Century* (Thorofare, N.J.: SLACK Incorporated, 2017).

44. Hogan, "Accessibility in Health Professions Education" (n. 17); Beth Linker, "The Business of Ethics: Gender, Medicine, and the Professional Codification of the American Physiotherapy Association, 1918–1935," *J. Hist. Med. & Allied Sci* 60, no. 3 (2005): 320–54.

45. Anderson and Reed, *The History of Occupational Therapy*, 102–9 (n. 43).

and managerial oversight from medicine, to maintain their status as a legitimate profession.[46]

After the war, physical and rehabilitation medicine, a newly recognized medical specialty, became a particular threat to PT's autonomy. In response, beginning in the 1950s, APTA maneuvered to pass licensure laws in each U.S. state and to otherwise dissociate PTs from the oversight of medicine. Eventually, this involved successful state-by-state campaigns to give PTs legal direct access to patients—without a physician referral—as well as the removal of AMA from a shared role in accrediting PT education programs. These hard-won battles to enhance their professional autonomy paid off greatly in the long run—giving APTA a much stronger hand in gaining reimbursement and recognition from Medicare and other emergent third-party payers.[47]

AOTA was much slower to solidify its professional status and recognition by state legislatures and federal healthcare programs. Postwar leaders in OT were less inclined than their APTA colleagues to mirror the professionalization approaches of medicine. AOTA did not begin to seriously pursue state licensure until the 1970s. As a result, OTs were not initially included as primary providers in Medicare legislation. Decades of effort were required to correct this.[48] In the 1970s and 80s, AOTA spent significant resources lobbying for licensure in each U.S. state.

Limited access to Medicare reimbursement during this period led to existential financial threats for AOTA and its members.[49] OTs also struggled to familiarize physicians, legislators, patients, and third-party payers with the nature and value of their clinical services. During the late twentieth century, AOTA invested heavily in efforts to better promote OT and facilitate its recognition as a respected and necessary health profes-

46. Wendy Murphy, *Healing the Generations: A History of Physical Therapy and the American Physical Therapy Association* (Alexandria, Va.: American Physical Therapy Association, 1995), 136–40; Quiroga, *Occupational Therapy* (n. 43).

47. Gritzer and Arluke, *The Making of Rehabilitation* (n. 5), 124–29; John L. Echternach, "The Political and Social Issues That Have Shaped Physical Therapy Education Over the Decades," *J. Phys. Therapy Educ.* 17, no. 3 (2003): 26–33; Marilyn Moffat, "The History of Physical Therapy Practice in the United States," *J. Phys. Therapy Educ.* 17, no. 3 (2003): 15–25.

48. Gritzer and Arluke, *The Making of Rehabilitation* (n. 5), 135–45; "Licensure Update 1985," *OT Newspaper* 39, no. 11 (1985): 4; Anderson and Reed, *The History of Occupational Therapy* (n. 43), 195–28.

49. "Congress Approves Occupational Therapy Medicare Amendments—president Carter Signs into Law," *OT Newspaper* 35, no. 1 (1981): 1; "The Medicare Amendment: Accomplishment of a Goal," *OT Newspaper* 40, no. 12 (1986): 1.

sion.[50] As I describe in upcoming sections, these differences in the identity, status, and financial positioning between AOTA and APTA directly influenced the timing and trajectory of their minority recruitment and inclusion efforts.

Gender dynamics in OT and PT also shaped each field's professional associations, workforce concerns, and engagement in minority initiatives. Both were majority female professions, though OT was more dominated by women, in numbers (over 95%) and leadership. Only one man has been elected as AOTA President since 1947. PTs were closer to 70% women and APTA had a long string of exclusively male presidents between 1967 and 1985, as well as a disproportionate number of men in other leadership positions. In the 1960s and 70s, existing personnel shortages in OT were compounded by the prevalence with which educated white women left the workforce. A 1972 study found that more than one-third of OTs were not currently employed and about 20% were working part time. As a result, a significant focus of workforce recruitment efforts by AOTA was encouraging and easing the re-entry of older OTs.[51] Notably, this strategy did not alter the overwhelmingly white demographics of the OT field.

A Notable Absence of AOTA Minority Initiatives

Amidst the challenges and priorities that the OT field faced during the 1970s and 80s, AOTA entirely overlooked minority recruitment, retention, and inclusion. The association did not develop any minority-specific awards or scholarships and had no advisory committees to make recommendations on minority issues prior to the late 1980s.[52] This absence of initiatives did not go unnoticed by AOTA members, among whom 5% identified as minorities in 1977.[53]

50. Institute of Medicine, *Allied Health Services* (n. 1), 29–34; Donna Healy Hamer, "Commentary: Why Do Occupational Therapists Avoid Explaining Occupational Therapy?," *OT Newspaper* 38, no. 12 (1984): 2; AOTA Communications Division,"Spotlight on OT: The AOTA Engagement Calendar—a History," *OT Newspaper* 35, no. 2 (1981): 5; Alice Punwar, "Readers Write: On Soap Opera Scripts," *OT Newspaper* 39, no. 7 (1985): 2

51. Anderson and Reed, *The History of Occupational Therapy*, 359–60 (n. 43); Murphy, *Healing the Generations* (n. 46), 250; Leon Bernstein, "Medicare and the Occupational Therapist," *Amer. J. Occup. Therapy* 22, no. 5 (1968): 390–95; "AOTA Delegate Assembly Minutes," *Amer. J. Occup. Therapy* 23, no. 6 (1969): 520–31, 522; "AOTA Delegate Assembly Minutes," *Amer. J. Occup. Therapy* 25, no. 7 (1971): 371–82, 379; Alice C. Jantzen, "Some Characteristics of Female Occupational Therapists, 1970, Part 1: Descriptive Study," *Amer. J. Occup. Therapy* 26, no. 1 (1972): 19–26.

52. "Proposed Resolutions and COP Documents," *OT Newspaper* 40, no. 2 (1986): 9–13, 9; Black, "Occupational Therapy's Dance with Diversity," (n. 6).

53. "Data Line: AOTA's Member Data Survey—a Summary," *OT Newspaper* 33, no. 2 (1979): 3.

When OT students at the University of Wisconsin published a review of AOTA's 1979 promotional calendar, they lamented that no Black OTs appeared in its pages.[54] A few years later, Valerie Barnes, a Black OT and president of AOTA's Washington, D.C. chapter, brought up this issue again. Barnes noted that in the 1981 calendar, no Black or minority OTs were shown. This time, AOTA responded, swiftly and dismissively, stating that all of the submissions featuring minority OTs, "were eliminated because of their photographic quality or because the subject was better represented by another photograph."[55] The primary purpose of AOTA's calendar was to show people outside of the field, including physicians and the public, what OTs do. Each year, development of the calendar was organized as a contest, in which AOTA members submitted photos for selection. The instructions noted, "Occasionally, photos are taken by arrangement because a particular subject is an important issue."[56] Clearly, addressing the lack of representation and inclusion of Black OTs in the profession was not a top priority for AOTA.

Importantly, the OT field *did* have many prominent and activist minority practitioners. In 1969, Lela Llorens was the first Black OT chosen to give AOTA's annual Eleanor Clarke Slagle Lecture—one of the field's most significant achievements.[57] Five years later, Llorens was among the founding members of the Black Occupational Therapy Caucus (BOTC), an organization that remained independent of AOTA, though it held meetings at AOTA's annual conferences. In the 1970s and 80s, BOTC took on some of the minority recruitment and support efforts that were institutionalized by APTA during this period, but that had not been pursued by AOTA. This included establishing an annual scholarship for Black OT students and an award recognizing the efforts of local BOTC chapters to recruit and support Black OT students and practitioners.[58]

BOTC also worked to address the crisis of limited access to OT services, practitioner-patient concordance, and career opportunities for Black communities. Caucus members provided professional mentoring and facilitated networking; worked to counter the discrimination that Black students and practitioners experienced in education programs and clinical settings; and organized to improve the recruitment of Black OT

54. "Spotlight on OT In the Public Eye—A Critique of the 1979 AOTA Promotional Calendar," *OT Newspaper* 33, no. 4 (1979): 5.

55. Valerie A. Barnes, "Readers Write," *OT Newspaper* 35, no. 5 (1981): 6.

56. "Spotlight on OT in the Public Eye" (n. 54).

57. Lela A. Llorens, "1969 Eleanor Clarke Slagle Lecture, Facilitating Growth and Development: The Promise of Occupational Therapy," *Amer. J. Occup. Therapy* 24, no. 2 (1970): 93–101.

58. Saburi Imara, "'Buffy' Bufford Receives BOTC Scholarship," *OT Week* 7, no. 32 (1993): 6; Robinson, *The Black Occupational Therapy Caucus* (n. 11), 69–70.

students, beginning with community outreach efforts. BOTC informed AOTA of these approaches and encouraged their wider adoption.[59]

AOTA was very slow to adopt minority initiatives. In large part, this was because a significant portion of the association's efforts in the 1970s and 80s were focused on improving OT's beleaguered status in the health care marketplace—due to the profession's lack of state licensure and primary provider status under Medicare. Realistically, AOTA had limited flexibility and resources to take on new initiatives when the OT field was under severe financial pressure.

Throughout this period, AOTA also struggled to establish OT as a legitimate field in the eyes of overwhelmingly white-male-dominated medical and government institutions. Beyond a purely financial assessment, AOTA's decision making should also be considered through the intersectional lens of Black feminist critical theory.[60] AOTA's leaders were almost exclusively white women, and so it is unsurprising that they prioritized meeting the expectations of white-male-dominant institutions, especially since sexism strongly shaped health fields' professional status. Importantly, AOTA pursued these goals to the exclusion of addressing the interlocking systems of oppression that shaped the experiences of minority OTs—who were primarily Black women.

In comparison, APTA had already attained many markers of white-male establishment recognition and legitimacy by 1970, including the PT field's achievement of universal state licensure and primary provider status in Medicare. Between 1967 and 1985, white males dominated APTA's national leadership. As men, these officers were positionally less attuned to systemic sexism—though it was certainly present in the association and PT field.[61] Being minimally encumbered by gender-based oppression, APTA's male leaders likely felt more empowered to engage with Civil Rights Era concerns—by committing attention and resources to the recruitment and inclusion of minority men and women in PT. Ultimately, AOTA's leaders did not turn their attention to minority initiatives until

59. Robinson, *Black Occupational Therapy Caucus* (n. 11), 32–48.

60. Angela Y. Davis, *Women, Race, and Class* (New York: Random House, 1981); Patricia Hill Collins, "Learning from the Outsider Within: The Sociological Significance of Black Feminist Thought," *Soc. Problems* 33, no. 6 (1986): S14–32; Alexandra Rutherford and Tal Davidson, "Intersectionality and the History of Psychology," *Oxford Research Encyclopedia, Psychology* (2019): https://doi.org/10.1093/acrefore/9780190236557.013.468.

61. Echternach, "Political and Social Issues" (n. 47); Moffat, "The History of Physical Therapy" (n. 47); Murphy, *Healing the* Generations (n. 46), 250; "Executive Director of the Women's Center Speaks to the Board of Directors," *PT Mag.* (May 1994): 101; Alison Wylie, "Why Standpoint Matters," in *The Feminist Standpoint Theory Reader*, ed. Sandra G. Harding (New York: Routledge, 2004), 339–51.

the late 1980s, when the OT field's finances had begun to stabilize and manpower shortages became a dominant concern.

The Rise and Decline of AOTA Minority Recruitment

The entrance of AOTA into minority recruitment, retention, and inclusion—nearly twenty years after APTA's initial efforts—began as a reaction to severe workforce shortages. During the early 1980s, AOTA conducted a multiyear manpower study to help facilitate future workforce planning.[62] The final report, published in 1985, encouraged increased emphasis on student recruitment. As part of this, the authors specifically argued for AOTA to take on, "a new commitment," by initiating, "a vigorous effort aimed at attracting and retaining minorities in the profession."[63] A few years later, this language and set of recommendations were closely mirrored by IOM's *Allied Health Services: Avoiding Crises*. Notably, one of the IOM report's primary authors, Florence Cromwell, was a former AOTA president and current IOM member.[64]

By the mid 1980s, many OT education programs were in a tenuous position. Despite the growing demand for OT services, federal government support for health education had declined significantly since 1976.[65] Applications and enrollment in OT training programs were also down. This was, in large part, due to a decrease in the college-aged population, which was anticipated to continue through the mid 1990s. Amidst these trends, AOTA's 1985 manpower report presented recruiting more minority students to OT education programs as a promising strategy for countering declines in enrollment and addressing manpower shortages. A few years later, IOM's parallel report made similar arguments.[66] In doing so, both organizations instrumentalized minority recruitment with the ambition of helping to address allied health manpower concerns.

In 1986, AOTA's Representative Assembly approved a resolution to study successful programs for minority recruitment and retention, with the goal of increasing the number of minority students and practitioners in OT. The resolution had been submitted by AOTA's Commission on Education, who explicitly acknowledged that, "There has been no recent effort by the American Occupational Therapy Association to increase

62. "Proposed Resolutions," *OT Newspaper* 35, no. 1 (1981): 8–15, 9.
63. Masagatani et al., *Occupational Therapy Manpower* (n. 10), 5, 7.
64. Institute of Medicine, *Allied Health Services* (n. 1).
65. Masagatani et al., *Occupational Therapy Manpower* (n. 10), 47.
66. Ibid., 7, 44; Institute of Medicine, *Allied Health Services* (n. 1), 4.

recruitment and retention of minorities within the profession."[67] AOTA's Executive Board chose Joyce Lane, a Black OT and BOTC's former and first chairperson, to lead the association's minority recruitment efforts.[68] In 1988, AOTA began an ad hoc minority advisory committee and a Minority Affairs Program in its national office, which was directed during much of the 1990s by Shirley Wells, a Black OT.[69]

Over a six-year period of intense engagement, Wells brought much greater attention to the crisis of racial/ethnic minority underrepresentation in OT and the related lack of access to OT services and career opportunities for minority populations.[70] A primary outlet for her efforts was AOTA's weekly professional magazine and employment bulletin, *OT Week*. Launched in 1987 to promote the copious job advertisements that existed for OTs across the United States, *OT Week* also featured significant professional and association content. In 1989, AOTA purchased *OT Week* from its publisher, viewing it as a valuable revenue source, which it was for nearly a decade.[71]

In *OT Week*, Wells established a regular column on minority affairs-related issues, which included the perspectives, achievements, and concerns of racial and ethnic minorities, as well as other underrepresented groups in OT—including disabled people and men.[72] Wells' articles introduced OTs (who were still over 90% white) to the history of Black, Latinx, and Indigenous lives, experiences, and cultures in America. She addressed the long-term impacts of slavery and segregation, societal bar-

67. "Proposed Resolutions and COP Documents" (n. 52), 9.

68. Robinson, *Black Occupational Therapy Caucus* (n. 11), 35, 48; "Lane Chairs Minority Study," *OT Newspaper* 40, no. 9 (1986): 1.

69. "New AOTA Position Focuses on Minority Affairs," *OT Week* 4, no. 39 (1990): 10; "Changing Faces at National Office," *OT Week* 6, no. 36 (1992): 22–23; Shirley A. Wells, "The Minority Affairs Program is Just Beginning," *OT Week* 6, no. 38 (1992): 9; Shirley A. Wells, "10 Years of Addressing Diversity," *OT Week* 11, no. 45 (1997): 16–17.

70. Wells, "10 Years" (n. 69); Shirley A. Wells, "Issues in Minority Affairs: Managing Diversity in Health Care," *OT Week* 7, no. 29 (1993): 6–7; Shirley A. Wells, "Beyond Recruitment: Achieving Diversity Requires Many Components," *OT Week* 7, no. 44 (1993): 16–18; Shirley A. Wells, "Issues in Minority Affairs: A Mentoring Program," *OT Week* 8, no. 23 (1994): 8; Shirley A. Wells, "Multicultural Affairs: A Snapshot of OT Educational Programs and Students," *OT* Week 10, no. 41 (1996): 9.

71. "AOTA Launches New Employment Bulletin," *OT Newspaper* 40, no. 12 (1986): 1; "A Summary of the Minutes of the Executive Board Meeting, October 1986," *OT Newspaper* 41, no. 1 (1987): 16–17; "Extra," *OT Newspaper* 43, no. 6 (1989): 1, 8.

72. Shirley A. Wells, "Issues in Minority Affairs: The Other Minority," *OT Week* 6, no. 50 (1992): 7; Shirley A. Wells, "Issues in Minority Affairs: Who Are the Men in Occupational Therapy?," *OT Week* 8, no. 12 (1994): 10; Shirley A. Wells, "Issues in Minority Affairs: An Environment of Acceptance," *OT Week* 8, no. 28 (1994): 8.

riers, and discrimination that impacted minority health, and the ongoing realities of racism.[73] The Minority Affairs Program also spotlighted numerous minority OTs in *OT Week*, highlighting their accomplishments and leadership. As part of this, Wells featured accounts of up and coming minority OT clinicians, educators, business owners, and researchers.[74]

AOTA's Minority Affairs Program was very active during its short tenure in helping to facilitate and enhance mentorship and support for minority OTs. As part of this, Wells and *OT Week* contributed to the development, promotion, and growth of multiple new minority support networks for Latinx, Indigenous, Asian, and disabled OTs. Like BOTC, these networks were established and run separately from AOTA, but often held meetings at its annual conferences.[75] The focus of AOTA's Minority Affairs Program extended to disabled OTs as well, though to a lesser degree than racial/ethnic minorities. In comparison, APTA's minority affairs efforts only rarely addressed disabled trainees and professionals. While the unique needs and experiences of disabled students and practitioners were occasionally recognized, enhanced recruitment of disabled individuals was never a serious focus of either association's minority initiatives.[76]

Importantly, in contrast to APTA's efforts, AOTA did not establish any minority-specific awards, scholarships, or fundraisers. These particular strategies help to institutionalize minority initiatives, by making them a recurring and prominent part of annual conference award ceremonies and by creating independent sources of financial support. Unfortunately, many of Wells's endeavors to improve racial/ethnic minority recruitment

73. Shirley A. Wells, "Defining the "Hispanic" Population," *OT Week* 7, no. 39 (1993): 10–11; Shirley A. Wells, "Issues in Minority Affairs: The First Americans," *OT Week* 7, no. 47 (1993): 8; Shirley A. Wells, "The African-American Culture," *OT Week* 8, no. 7 (1994): 24–25; Shirley A. Wells, "African-American Women: Our Unsung Heroes," *OT Week* 9, no. 8 (1995): 22–23; Shirley A. Wells, "Multicultural Affairs: An Uncelebrated Heritage," *OT Week* 10, no. 7 (1996): 8.

74. Shirley A. Wells, "A Legacy of Involvement," *OT Week* 7, no. 5 (1993): 18–19; "Keep Your Eye on . . . Linda A. Williams-Brown," *OT Week* 7, no. 16 (1993): 7; "Emerging Minority Leader: Keep Your Eye on . . . Lynette Byarm," *OT Week* 7, no. 25 (1993): 9–10; Shirley A. Wells, "The Multicultural Affairs Program," *OT Week* 9, no. 3 (1995): 9.

75. Shirley A. Wells, "Issues in Minority Affairs: A Mentoring Program," *OT Week* 8, no. 23 (1994): 8; Shirley A. Wells, "A Network for Native Americans," *OT Week* 8, no. 44 (1994): 8; Barbara E. Joe, "Unity Through Diversity," *OT Week* 9, no. 21 (1995): 24–26; Jamie Phillip Munoz, "Diversity Through Inclusion," *OT Week* 9, no. 25 (1995): 18–19; "Issues in Multicultural Affairs: Calling Asian/pacific Therapists," *OT Week* 10, no. 22 (1996): 9; Barbara E. Joe, "The Well-Connected Therapist," *OT Week* 11, no. 40 (1997): 16–17; https://ojotc.org/mdi/ (accessed May 11, 2022).

76. Wells, "Issues in Minority Affairs: The Other Minority" (n. 72); Ellen N. Woods, "When It's the Physical Therapist Who Has the Disability," *PT Mag.,* June (1993): 42–47.

and inclusion in OT disappeared during the late 1990s, due to a severe decline in the OT job market and renewed financial duress.

In 1998, AOTA's minority initiatives came to a sudden halt. The Minority Affairs Program was discontinued, and Wells's position was terminated. The impetus was financial. In the Balanced Budget Act of 1997, the U.S. Congress had approved a new $1500 cap on Medicare reimbursement for outpatient OT and PT services. The immediate impacts on the OT job market were catastrophic. Several thousand OTs were laid off or saw their hours severely cut because employers assumed that, under the cap, offering OT services would no longer be profitable.[77] As a result, AOTA membership began to decline and workforce shortages ceased to be an issue.[78]

Importantly, AOTA also experienced a huge loss of revenue from *OT Week*, due to the sudden evaporation of job postings. Financial reports published in *OT Week* showed that the association had been making millions of dollars annually from the periodical. In 1999, the loss of job advertisement revenues amounted to a 12% hole in the association's annual budget. AOTA's Executive Board reacted swiftly, making major cuts at its national office, which included the dissolution of its minority recruitment initiatives.[79] *OT Week* was discontinued in late 1999 and its professional content was folded into *OT Practice*, another AOTA periodical.[80]

As part of these cuts, previous commitments to increase the diversity of the OT profession were removed from AOTA's strategic plan and minority inclusion efforts were no longer identified as an association priority.[81] In 1999, a collation of OT minority support networks submitted two resolutions to AOTA's national Representative Assembly, calling for the reinstatement of the Minority Affairs Program. Both were defeated.[82]

77. Christina Metzler, "An Ideal Time for OT Action," *OT Week* 12, no. 7 (1998): 7; "OTAs Speak Out: Surviving PPS and Building a Better Future," *OT Week* 13, no. 33 (1999): 8–10.

78. Lynne Barnes, "AOTA Financial Report, July 1, 2000–March 31, 2001," *OT Practice* (July 16, 2001): 19–20.

79. Doris Gordon, "Treasurer's Report: Fiscal Year Ended June 30, 1997," *OT Week* 11, no. 39 (1997): 8–9; "Treasurer's Report: Results for First Quarter Ended Sept. 30," *OT Week* 12, no. 32 (1998): 2; Paula A. Steib, "From the Editor: OT Week is Here to Stay," *OT Week* 12, no. 52 (1998): 2; "1999 RA Resolutions," *OT Week* 13, no. 5 (1999): RA2–RA12; Lynne Barnes, "AOTA Financial Report: Fiscal Year 1998-'99," *OT Week* 13, no. 39 (1999): iii–iv.

80. "Announcing an Important New Merger," *OT Week* 13, no. 38 (1998): 2; Paula A. Steib, "From the Editor: To Everything, There is a Time," *OT Week* 13, no. 39 (1999): 4.

81. Karen Jacobs et al., "Strategic Planning at Work: An Update," *OT Week* 10, no. 30 (1996): 20–21; Thomas Fisher, "Association Sharpens Focus with Updated Strategic Plan," *OT Week* 12, no. 23 (1998): 6–7; Thomas Fisher, "Strategic Plan Update," *OT Week* 12, no. 47 (1998): 2.

82. "1999 RA Resolutions," RA4-RA8 [Resolutions C and H]; Kathryn M. Loukas and Paula A. Steib, "Results From the 1999 Meeting of the RA," *OT Week* 13, no. 17 (1999): 8–9.

Diversity-related content in *OT Week*, and later *OT Practice*, noticeably declined. During the early 2000s, articles addressing diversity focused on cultural sensitivity and awareness as a professional ethics issue, instead of minority recruitment and mentorship.[83] Indeed, while interest in minority initiatives and inclusion had been robust for nearly a decade, these efforts were no longer treated as AOTA priorities when financial pressures inevitably arose and the OT job market tightened.

The $1500 Medicare cap also applied to PT services, and APTA lost members during this period as well, but never resorted to the same drastic cuts as AOTA. In part, this was because APTA had not chosen to purchase *PT Bulletin*, the sister employment bulletin to *OT Week*, and its budget did not depend heavily on job ad revenues.[84] As the pages of *PT Magazine* show, APTA's Office of Minority Affairs was retained and its annual minority awards, scholarships, and fundraiser continued and grew.[85] Over the long term, APTA's institutionalized and recurring investments in minority recruitment, retention, and inclusion proved to be more concrete and less expendable than AOTA's briefly intensive, but much more transient, focus and commitments.

Concluding Remarks

Relative to the growing diversity of the U.S. populace since 1970, the proportion of racial/ethnic minority practitioners in OT and PT has changed little over the past half century—despite sincere, if limited, recruitment,

83. Penny Kyler, "The Ethics of Cultural Competence," *OT Week* 13, no. 25 (1999): 3; Cynthia Hughes Harris, "Educating Towards Multiculturalism," *OT Practice* (March 13, 2000): 7–8; Janie B. Scott, "Cultural Awareness and Sensitivity," *OT Practice* (July 2, 2001): 7; Janie B. Scott, "Cultural Awareness Follow-Up," *OT Practice* (November 5, 2001): 6; Janie B. Scott, "AOTA Staff Responds to Multicultural Recommendations," *OT Practice* June 24 (2002): 15–16; Janie B. Scott, "Expanding Cultural Awareness and Sensitivity," *OT Practice* (May 19, 2003): 13–14.

84. Christina Metzler, "AOTA Backs New Legislation to Repeal $1500 Cap on Outpatient Therapy Services," *OT Week* 12, no. 21 (1998): 5; American Physical Therapy Association, *Annual Report 1997* (access courtesy of the American Physical Therapy Association); American Physical Therapy Association, *Annual Report 2001* (APTALA); "PT Magazine Launched," *100 Milestones of Physical Therapy* (American Physical Therapy Association, 2021), https://centennial.apta.org/timeline/pt-magazine-launched/ (accessed May 17, 2022); "PT—Magazine of Physical Therapy is Renamed PT In Motion," *100 Milestones of Physical Therapy* (American Physical Therapy Association, 2021), https://centennial.apta.org/timeline/pt-magazine-of-physical-therapy-is-renamed-pt-in-motion/ (accessed May 17, 2022).

85. "Capital Campaign Raises $90,000 for Minority Scholarship Fund," *PT Mag.* (July 2001): 8; "A Plan of Many Colors," *PT Mag.* (November 2005): 42; Eric Ries, "An Honor with Multiple Pay-Offs," *PT Mag.* (July 2007): 48–53.

retention, and inclusion efforts. Throughout this period, the numbers of underrepresented racial/ethnic minority practitioners in OT and PT remained extremely low. In 2020, 36% of Americans were part of underrepresented racial/ethnic minority populations, but only around 11% of PTs and 14% of OTs.[86] Stepping back from demographic representation as a primary measure for assessing the success of racial/ethnic minority recruitment and inclusion, in this article, I suggest that another meaningful basis for comparison is the motivations behind, and continuity of, investments in minority initiatives.

Unlike some of its peer health professional associations, AOTA did not begin minority recruitment efforts during the civil rights era. Throughout this period, AOTA was distracted by the severe financial stress that the field faced because OT was not recognized as a primary service for Medicare reimbursement. In response, AOTA's leadership focused on enhancing the field's legitimacy in the eyes of white-male-dominated medical and government institutions, instead of attending to the interlocking racial and gender oppression that impacted minority practitioners.

During the late 1980s, AOTA first invested in minority recruitment initiatives as a strategy to address severe workforce shortages. Though Shirley Wells expanded the ambitions of these efforts, the true significance of minority recruitment for AOTA was revealed when the association decided to end its Minority Affairs Program and remove minority recruitment and inclusion from its list of priorities, following the severe job market decline and renewed financial stressors of the late 1990s. Notably, AOTA had not institutionalized any annual minority-specific awards, scholarships, or fundraisers, which might have survived this period of uncertainty.

In comparison, APTA's slow and steady approach to racial/ethnic minority recruitment and inclusion proved to be more robust. Though initially tied to workforce shortages, APTA's minority initiatives were soon decoupled from manpower concerns and grew to involve annually recurring minority-specific awards, scholarships, and fundraisers. Importantly, even during inevitable periods of job market downturns and financial difficulty, these awards and scholarships continued. The establishment of an annual fundraising gala for minority initiatives helped to keep them

86. Prisca M. Collins and Cynthia Carr, "Exposure to, Knowledge of, and Interest in Occupational Therapy and Physical Therapy as Career Options," *Open J. Occup. Therap.* 6, no. 2 (2018): Article 12; Association, American Physical Therapy, *APTA Physical Therapy Workforce Analysis* (Alexandria, Va.: APTA, 2020), https://www.apta.org/contentassets/5997bfa5c8504df789fe4f1c01a717eb/apta-workforce-analysis-2020.pdf (accessed May 16, 2022); United States Census Bureau, "Quick Facts," (2021), https://www.census.gov/quickfacts/fact/table/US/PST045221 (accessed May 16, 2022).

going. Additionally, these forms of professional recognition were institutionalized in APTA committees and included as part of the association's annual national conference, at which awards were prominently given out alongside other citations of excellence.

The underrepresentation of racial/ethnic minorities in nearly all clinical professions has a structural and historical basis, rooted in exclusion and discrimination, limited access to health services, and major disparities in educational opportunities and support.[87] These complex and deeply embedded societal and professional issues cannot be adequately addressed through strategies targeted to more transient concerns, like workforce needs. Effective initiatives to enhance minority recruitment and inclusion require long-term and consistent commitments, which, like APTA's efforts, must be insulated from cyclical financial and job market declines.

As health professional associations and academic institutions move forward with diversity, equity, and inclusion initiatives in the 2020s, there is an ongoing need for critical assessment. One of the major drivers for AOTA to initially pursue racial/ethnic minority recruitment initiatives during the late 1980s was a decline in enrollment that threatened OT's education programs—a problem largely caused by the demographic decline of college-aged students during the late 1980s and 90s. In response, AOTA turned to the "creative" strategy of recruiting from "untapped" student populations—foremost among them underrepresented racial/ethnic minorities.[88] Presently, as many universities are bracing for another demographic decline, they have once again identified enhanced recruitment from underrepresented racial/ethnic minority populations as part of the

87. Institute of Medicine, *Allied Health Services* (n. 1), 68; Nelson, *Body and Soul* (n. 2), 36–42; Lucey and Saguil, "The Consequences of Structural Racism" (n. 17); Institute of Medicine. *The Right Thing to Do, the Smart Thing to Do: Enhancing Diversity in the Health Professions* (Washington, D.C.: National Academy Press, 2001), 9; Hogan, "Accessibility in Health Professions Education" (n. 17).

88. Institute of Medicine, *Allied Health Services* (n. 1); Scholars of critical diversity studies have highlighted similar practices in the business world—instrumentalizing diversity initiatives to achieve larger economic goals. Sonia Liff and Judy Wajcman, "'Sameness' and 'Difference' Revisited: Which Way Forward for Equal Opportunity Initiatives," *J. Management* 33, no. 1 (1996): 79–94; Jill Blackmore, "Deconstructing Diversity Discourses in the Field of Educational Management and Leadership," *Educ. Management Admin. & Leadership* 34, no. 2 (2006): 181–99; Patricia Zanoni et al., "Unpacking Diversity, Grasping Inequality: Rethinking Difference Through Critical Perspectives," *Organization* 17, no. 1 (2010): 9–29; Michael Penkler, Kay Felder, and Ulrike Felt, "Challenging Diversity: Steering Effects of Buzzwords in Projectified Health Care," *Sci., Technol. & Hum. Val.* 45, no. 1 (2020): 138–63.

solution.[89] To avoid another era of instrumentalizing minority students to prop up admissions, we must remain active in examining and learning from the ideal ambitions, true financial motives, and long-term outcomes of past diversity initiatives.

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