

Profiles in Professionalism With Beth Skidmore

By Elizabeth R. Skidmore, PhD, OTR/L, FACRM and Melissa McCune, PT, DPT, MPH

This innovative series featured in the *Journal of Humanities in Rehabilitation* seeks to explore the elusive yet crucial concept of professionalism and its role in the field of rehabilitation medicine. Providing insight through the words of visionary leaders, we seek to reflect on what it means to be a professional in the current healthcare environment, and how the past can help to inform the future of our growing field. Through captivating video interviews, the concept of professionalism is presented in a format that aims to speak to rehabilitation professionals across the spectrum of clinical care, research, and education.

Introduction

In this installment of the “Profiles in Professionalism” series, we are honored to sit down with Elizabeth (Beth) R. Skidmore. Dr. Skidmore is a renowned and highly-respected clinician, researcher, and educator in the field of rehabilitative medicine. Her research focuses on learning more about the neurologic population and investigating interventions that promote independence and community integration among adults with cognitive impairments. In her interview, Dr. Skidmore touches on a range of interesting and critical topics that weave together the

multifaceted work of rehabilitative professionals and how different perspectives are needed for the profession to grow and thrive.

Biography



Dr. Skidmore is an occupational therapist with expertise in neurological rehabilitation. In addition to her primary appointment in the Department of Occupational Therapy at the University of Pittsburgh, she holds secondary appointments in the School of Medicine Department of Physical Medicine & Rehabilitation, the School of Nursing, and the Clinical Science Translational Institute. Skidmore is a scientist at the University of Pittsburgh Medical Center (UPMC) Rehabilitation Institute.

She is the recipient of the Pennsylvania Occupational Therapy Association Academic Educator Award and

the University of Pittsburgh's School of Health and Rehabilitation Sciences Dean's Distinguished Teaching Award. She is also the recipient of the Pennsylvania Occupational Therapy Association Inaugural Research Award, and the American Congress of Rehabilitation Medicine Deborah Wilkerson Research Career Award. In 2013, Skidmore was the first occupational therapist to receive the Presidential Early Career Award for Scientists and Engineers, the highest honor bestowed by the United States Government on early career scientists. Skidmore is a member of the American Occupational Therapy Foundation Academy of Research, and Fellow of the American Occupational Therapy Association and the American Congress of Rehabilitation Medicine.

How did your career as an OT start, and where do some of your interests lie now?

<https://vimeo.com/434025538/54165934b7>

... I decided to become an occupational therapist...at the end of my sophomore year as an undergraduate. I pursued undergraduate training at Western Michigan University and enrolled in the honors college with an undeclared major because I had a strong passion for the humanities and the sciences, and the honors college gave me an opportunity to explore both in my undergraduate studies while I decided on a major. When it came time to select a major, I started exploring a number of different options. Western Michigan University has one of the oldest occupational therapy programs, and I selected that over other options because of the opportunity to work with people in their everyday lives.

I explored a number of other health professions, and I liked the contact that I had with individuals in the occupational therapy environment, and I also liked the flexibility and creativity embedded in the field of

occupational therapy. So, I had the opportunity to blend my passion for people with understanding what makes them tick and helping them achieve their own goals. And in doing so, I learned a lot about the variety of different backgrounds that we have—the variety of priorities that people have—and I found that stimulating. And I think the other thing that attracted me to OT, candidly, was the opportunity to be trained in a profession that would allow me to work in a variety of work settings. I know that I have ... a low tolerance for routine, and occupational therapy allows for a lot of, you know, creative ways to express yourself. And I really thought I was going to get one degree, train one time, and have a whole career full of a variety of exciting opportunities. [It] didn't turn out to be that way, but that's what my thought was when I was 20 years old.

Almost immediately when I started occupational therapy classes, I had a passion for working with people with neurological disabilities. And so, I did a lot of volunteering, and I pursued fieldwork in sites that would give me opportunity to work with individuals with acute stroke, acute brain injury. That kind of lit up my imagination as to 'how do you help people learn a new normal?' And maybe a better normal than what they might have experienced before they met us, and experienced these tragic events in their lives.

...My very first job I actually selected due to geographic proximity with my family, because at that time my mom was not well. ...My first job was actually in long-term care. But then I quickly moved from that into working in inpatient rehab with a focus on stroke and brain injury, which then led me to another job, which then quickly led me to a desire to pursue graduate studies, and that's where I really desired to augment my education. I was in a position in the rehab hospital where I was being asked to make decisions

about what programming we would keep, what programming we would augment, what programming we'd get rid of. And I knew there had to be a better way to make those decisions than what I received in my bachelor's training as an occupational therapist. And so that's when I started to pursue training in evidence based practice, which led me to a master's degree at the University of Pittsburgh where I was trained in evidence based practice with a particular focus on neuro rehabilitation...and then I was bit by the bug of research and started to pursue doctoral studies and continue down the path that [I'm on] now.

What do you love most about being a leader in academia?

<https://vimeo.com/434030602/5819070a1a>

There are several things about academic leadership that give me joy—much to my surprise! I tried to avoid academic leadership, unsuccessfully. I really enjoy the mentoring relationships that academic leadership affords. So, the opportunity, of course, to mentor students at all different levels—entry level and advanced students, scientific students in training, faculty in training at all levels, junior faculty, mid-career faculty. Watching people set out goals and achieve them and, you know, recognizing their success, that's the biggest joy that I have in academic leadership and it is probably what keeps me engaged in it. [I'm] much more excited when one of the faculty gets their own grant than I've ever been about one of my own. I'm much more excited when somebody on our faculty gets an award than any award I've ever received! ...[I]t's fun to know that I may have had a small part in that.

One of my mentors early on in my career said to me that she was very excited about the fact that she thought I would well-exceed her contribution—probably not recognizing her contribution to my

success—but I understand that at a different level now. I hope and [I] am confident that the doctoral students that I am supporting now [and] the postdoctoral trainees that I'm supporting will go on to make an even bigger impact than I will ever achieve because they've benefited from...even more refined mentoring, [a] more exciting world, with more opportunities that ...just continue to open up for us. And I think, to me, that is the value of the work that we do...and I think it's not unlike the joy that I received from practice.

So...when a client comes to you and you're working with a client, it's not about your skill set or your knowledge base, right? It's about them. It's about their journey, and it's about where they want to go on their journey and how you can use the knowledge and skills that you have to help them realize their journey. And I don't get to claim those successes any more than I get to claim any failures...it's their journey [and] I have the privilege of walking [that] road with them for a while, and I think it's the same, just at a different level with trainees and with faculty.

When you think about professionalism, what comes to mind? How do you teach this to your students?

<https://vimeo.com/434033946/c6303603fe>

I think when I was younger, professionalism meant competency. It meant having a certain knowledge base and a certain confidence level to articulate [that] knowledge base or skill set. I think now professionalism means ...grace and humility to me. And I think I've learned that from people that I see as mentors who are at the top of their game by the world standards, right? They're highly competent and highly talented people, but they...exhibit their professionalism in the degree to which they listen and learn [from] others. And that's a level of

professionalism that I aspire to attain. I think I have room to grow there...but I think having a knowledge base and competency is the first step. Recognizing the knowledge and competency in others and using that...to collectively move [us] forward—I think that is professionalism. It is this...awareness of...[the fact that] we each have a small part to play, but it's our collective [knowledge and skills] that moves us forward. I think those that I see as [the] top...licensed professionals are those that lead us well in that regard. I think, with occupational therapy students, when we're looking to...focus on the development of [their] professionalism, we're getting them to, we hope, stimulate an “other-centered” focus. Just to be less concerned with the knowledge base or the competencies they're acquiring and more concerned with the needs of the people that they're seeking to serve.

I had a conversation with a group of students last week when we were talking a little bit about how the clients we serve have an expertise. They're experts in themselves, and our job is to help them recognize that expertise and harness that expertise. And we have a few tricks based on our knowledge or training or expertise...things that we've learned along the way, but our job is to be that facilitator and—as much as possible—try to get them to focus less on how well they handle a person or where they put their hands or how they speak or what words they use, and more on listening and understanding, and not assuming things about the clients that they serve. I think the better you understand [the] individuals that you serve as individuals, the better you can help them achieve their goals. I think that lines [up] very nicely with the core principles of the humanities, which is...the wonderful complexity and creativity and yet individuality that exists within people, and celebrating that rather than trying to minimize that.

I think those are the conversations that we have with students. I think often....in our professional curricula, we boil down professionalism to what we call “professional behavior,” right? So, we boil it down to these simple things, like how well do you show empathy, how well do you show up on time, are your assignments clean and neat, do you dress appropriately, do you use...culturally sensitive language? And those are pieces of it, but at the core of all of that is focusing less on self and more on others. If you're paying attention to the people that you're interacting with, those things will come naturally. And it's not a set of memorizations or rules to follow, it's just showing dignity and respect to the others that you interact with. I think that if we boil professionalism down to a set of characteristic behaviors, we miss the core element of professionalism, which is focus on a person other than self.

So when you walk into the physician's office and you're there for your examination and the physician is telling about what a difficult day he's had while you're waiting to get news, you're thinking 'he's not very professional because he's not thinking about anybody but himself right now,' right? And so, a lot of these...professional behavior checklists [are], in my view, an attempt to draw people to an awareness of the behaviors that detract from focusing on others. But the root of the issue is the degree to which I can put myself aside to identify what your need is and help you achieve that. I'm professing a belief that for the next few minutes you're the focus of my attention and that by doing that there's therapeutic value. That by figuring out where you are, where you need to go and how you're going to get there—that is my professional identity for right now, and everything else steps outside of that space.

How does an understanding and appreciation of diversity contribute to the work of rehabilitation

professionals?

<https://vimeo.com/434028893/d13e208520>

Occupational therapy really emerged from...several different ideological perspectives. One of them being the “moral treatment movement,” where individuals with disabilities were given the opportunity to show their purpose and dignity through occupations or meaningful activities, which ranged in scope. It was the idea that everybody has a way to contribute to society. So, if we have individuals with disabilities who aren't able to [for hard labor], they can still help contribute to the community by building whatever widgets that we need [in society] or by helping us understand the problems [that people face] because they look at the world differently, and really at the core of it, it's the root of these notions of diversity. . . . it's understanding that everybody has purpose and dignity, and it's a matter of finding that place where we each can contribute.

We were talking on the way over about disability studies versus medical model kinds of perspectives, right? The medical model tends to look at an individual and break down what's...maybe not functioning at an optimal level and then use that as a target for intervention to improve. You know, the disability-studies perspective—(and I think it emerges from some of these other perspectives)—is that there's not necessarily anything wrong with me, it's just there's a mismatch between my capacities and the environmental affordances. And the degree to which I can marry those to identify my purpose and to realize my dignity is the degree to which I have health. And in that model, society shares a responsibility as much as any individual, right? And it's putting that individual in community.

My pastor said something really profound a few weeks

ago, and I keep chewing on it—it's attached to my desk now. [H]e said, “Wisdom comes from humility, and humility comes from community, and it comes best from communities that are diverse.” The more we interact with people who think and act differently than us, the more we understand ourselves—which is what humility is. That's how I understand who I am in light of those around me. And the more I understand myself in light of those who are around me, the more wisdom I have about self and others, right? And that's the ultimate...goal, right? That's what we're here to learn.

How do things like art and history contribute to your work as an occupational therapist?

<https://vimeo.com/434027266/65a9b7fe32>

The attraction for me to things like art, history and literature, [and] philosophy, is the degree to which it helps me understand myself and others better. And I think all of that passes through my filter. Growing up..., faith was a big part of my life. So, I do admit that a lot of my thinking passes through that filter, but I also think that I inherently assume that anyone that I interact with has something to teach me. And I think I can learn that by looking at art I don't understand. I can learn that by reading a story about a character that makes decisions very differently than I would, by trying to understand what makes people tick; that's the root of the issue for me.

And that's why occupational therapy is such a good fit, because that's at the root of the issue of occupational therapy:...what makes someone tick? What is going to help them achieve their goals? What are the barriers, whether they are environmental or self-imposed, that are in the way, and how can we call those out and address those [barriers]? And let's not make any judgment or assumptions about right and wrong because, generally speaking, people end up in the

circumstances they end up in as a result of a number of choices, and those choices have been influenced by [a variety of] life experiences. So, let's not judge [those experiences]. Let's understand them, and then let's [work together to] figure out where they want to go.

How can the humanities help us better understand ourselves and others? Do the humanities continue to hold value in OTD and DPT education?

<https://vimeo.com/434035873/faeb0ae658>

Part of my undergraduate education in the Lee Honors College at Western Michigan University was very creative, and so a lot of my thinking was influenced by that at an early age. We took these 'integrated clusters' (...what they were called), and they would marry things like a political science class with a class in Shakespeare and then a writing seminar. And we looked at political science themes in Shakespearean writings, and we looked at how Shakespeare talked about the lived experience of the impact of those political themes and how it influenced literature at that time. And it forced me to do a level of synthesis at a very early age to try to understand these connections. There were many creative STEM clusters where we would, you know, add math and calculus with some body of literature or history. One of my colleague's honors thesis was an operetta that he wrote using [the] Fibonacci sequence. The story was on a famous Russian folk tale, but the music was based on the Fibonacci sequence, which just kind of brought a symmetry to the music that laid out the story. It was beautiful and you walked away feeling like you were in a special place for a period of time. We were encouraged at a very early age, long before we were professionals or even seeking professional training to try to understand the world through this more complicated lens.

And I'm so grateful for that. I think it gave me new insight [into] myself, what I did and didn't understand, and gave me confidence to interact with people, to try to understand things that were new and foreign to me, and to do it in a respectful way. I think it's just a matter of navigating some of that. I remember...this was when we were bachelor's-trained therapists, so it was a while ago. It was a different world. We all had an undergraduate education and often liberal arts [courses before we enrolled in] a senior-level professional training program. I remember [a faculty member] lamenting that she felt that the professional educational world was moving more and more [toward] technical specifications and that she wanted her physician when he came in to see her, to have some thoughts and emotions and reactions to a painting by Degas, and that we needed to make sure that we were augmenting any professional education we were getting with these experiences.

So, while I was in my OT training, I took a course in non-Western music, and I participated in an international keyboard festival where I learned about all different types of music and, you know, just an opportunity. And then I wrote a paper that tied it back to my major. So, I wrote about motor learning and learning how to play the piano and neural plasticity, and it fit. But in the meantime, I could still appreciate the music, right? And so, I think it has been one of my fears, particularly as we've gone to master's and doctoral education. We do have a number of students that are coming from the humanities but fewer and fewer—[but] many of them [students] have moved along the pipeline of biology or physiology to increase their competitiveness for programs.

And I almost wonder if sometimes we should take a step back and protect a few slots [for students from the humanities] because it is the French majors that bring

a different perspective to our OT professional program. It's the people who have had careers in elementary education. It's the folks who have backgrounds in art history, or graphic design, or who look at the world with a different lens than those who kind of come up through the STEM fields. I think our classes and our professions are richer with that diversity of training, but I worry that we lose it a little bit. Sometimes folks just get so much in the rut of, 'I got to do this to get into the program, and then I got to have these prerequisites' and they don't necessarily consider if they've had a different path, rehabilitation is a potential direction.

What role do rehabilitation professionals play in the community and how can we better integrate that into daily clinical practice and education?

<https://vimeo.com/434037678/bf03f9f443>

One of things that we have been spending a lot of time thinking about is, How do we attract more people to the profession who come from different racial and ethnic backgrounds or socioeconomic backgrounds? And we recognize in order to do that, we need to interact with these communities where these children live. We can't wait [until] high school; we [have] to start in elementary school and middle school, and we need to make sure they know that rehabilitation is an option, because most of them, if you interview them, you'll ask them, "What are the professionals that you know?" It's teacher, lawyer, doctor. Those with the three that they interact with, and if they knew that rehab was an option—pick any of our disciplines—if they knew that was an option, they might pursue it.

But then I think simultaneously we need to talk about the multiple paths to get there, because I think some paths will fit for some of these students and other paths will fit other students, and we need to make sure

to ensure their success. So, one of the things our university is doing that I just think is brilliant, is they've invested in these community engagement centers, particularly in underserved neighborhoods within our community where there is no 'take' involved. It's all give, and we've worked with those communities to try to understand what they think their needs are as it relates to the economic needs, health needs, structural civic needs, whatever the case may be. And then we have created centers in those communities where we have students going in and working with these families to be responsive to those needs.

We see one of the options that we can do is career training. One of the things they've asked to be exposed to [is], 'What are the options for me and where are the various pathways?' And what a great way to model, but also what a great way to train our students in the real-life needs of our communities and getting them to understand the complexities of real life in a variety of different settings. We find that these settings are one of the best opportunities for our students to practice at the top of their license because they're not bound by the rigid structure of a health system or an outpatient clinic, and so we can really get at the intersection of real life and real need and it's allowed them to design programs and test them and implement them in very creative ways that make a direct impact on the community, but also likely expose youth to a variety of career options as they grow and change. Our university is very generous in providing a number of scholarship and funding opportunities for students from these communities, but they have a hard time recruiting them, and it's because we don't engage these communities at the level that we could, and it speaks to my heart because I started out in rural health.

Even as a fieldwork student, I did a Level I field work in hospice with the supervision of an OT faculty

member. It was an experiment and it was in these widespread rural communities in western Michigan, southwestern Michigan, and I was in people's homes—doesn't get any more real than that—with people who have been given terminal diagnoses, thinking about creative ways that we could help them optimize the days they had left. And, you know, interventions ranged from helping one woman with a brain tumor read a book to her newborn grandchild, to teaching a husband how to move his wife in the bed to change the sheets without causing her pain, despite her stage-four extremely painful bone cancer. So, just handling. To one guy, we redid his bathroom with the help of some community funds so that he could get in and not have to rely on his sister to navigate bathroom tasks. And, you know, it just doesn't get any better than that, right? In the meantime, I'm learning about their lives and what matters to them. And how do we make the days count?

And I learned a lot in rural health about need and access, and real-world barriers that I don't know that we address as well as we could in our educational training programs. When someone's coming to you in the hospital or coming to you in the clinic, you have 100% control over that environment and you have a low level of accountability, the degree to which it's really going to impact somebody's life, right? It's just a different animal than when you're in their community, you're in their homes, [for] whatever it may be you're going there. You share power, control over that space, and you have to negotiate and you have to come up with real-life solutions to real-life problems. They're no longer ignorable. When your client is having to choose between feeding her kids and getting some device or splint that the doctor says she needs, you can no longer ignore it. You can't ignore it. You've got to deal with it. And so...I think that it's such a great training environment. It also demystifies that environment and

hopefully our students will seek training and employment in settings like that. And not fear them, right?

I feel like we're much more likely to make a difference in our national public health if we embrace those types of opportunities. They are harder. They take more work and more investment in time, but I think [they're] much more likely to make an impact than the 12 people that run through my outpatient clinic on a daily basis. And that is filtered through my OT lens. I think the home and the community is the best place for us.

Where does “clinician burnout” come from and how can this be addressed through the humanities?

<https://vimeo.com/434039951/78051c5a4e>

I think a lot of it comes from this capitalistic notion of productivity, which in many cases feels in conflict with the humanism of the work that we do, right? That's the crux of what you hear from our health care practitioners. Pick a discipline. I don't have time to tend to the patient because I have these 50,000 procedures that I need to do and they're time-consuming. Great. You know, I do think that is what Medicare is thinking about when they're looking for ways to incentivize quality of care and outcomes and then leaving it up to health systems to figure out how they make that happen rather than trying to micromanage it.

But I think there's going to be a learning curve because up to now we've been incentivized for productivity, and so we're going to have to learn how to practice differently again, and we're going to learn how to optimize and staff systems differently again, and we're going to have to learn how the incentives and disincentives to good quality or poor quality, as the

case may be, can help us optimize the system. But at the end of the day, each of us controls our own fate. And I think that burnout, yes, is caused by this cognitive dissonance between the people I was drawn to when I chose my profession and the procedures that I have to do which are in conflict with each other; sometimes, at least, it feels that way.

But I also think a part of it is, this is a job that we choose to invest in others—and that investment is not without cost. It's not free for me to push myself aside all day long and then go home and have to pick it back up and deal with whatever else my world brings. It is not without cost, and I think the degree to which we care for ourselves is the degree to which we're able to continue to engage in that struggle. And we care for ourselves by connecting with others, in some cases by getting some alone time, and by being reminded of what humans are about, right?

And I think that's the value of humanity:...the degree to which...we stimulate our understanding, our ability to engage with art, literature, music, and history and all those things, and the degree to which we stimulate new ideas and new energy to go back in there and try it again. I don't think that I know a therapist that would ever say 'I have not experienced burnout.' And I think for some of us, yoga and meditation, mindfulness, are a piece of that solution. But I also think community is a huge part of the solution. And I don't know the degree to which we take advantage of that.

You know, back in the olden days, you had your monthly sit down, look at each other's goals, and give each other feedback, or we'd have someone come in and peer review a session of treatment and give us feedback. And, yeah, it was a little scary, but it also stimulated community—like, we're in this together. And we've lost some of that. And so, ...I know a

number of educational programs, but also health systems that are trying to resurrect this 'communities of practice' notion. So, what's the degree to which we have communities of practice within and across disciplines where we create time and space for discussion? And maybe what you do is, you read a book that has nothing to do with rehab, but you think a little bit about that person's life and what that might mean and how that could influence what we do. Certainly, there's a lot of work going around evidence-based journal clubs, but what's the degree to which we sit there and look at the art of some of our clients with disabilities and how they're trying to tell you their story in a different level of expression?

The occupational therapists at Walter Reed use self-expression in an amazing way. So, among returning soldiers and veterans who have severe injuries, whether [due to] polytrauma or amputations of any sort, they use stories and pictures to communicate what they're doing. One of the faculty that I work with, Alyson Stover, runs a clinic for youth and young adults with addiction, and they draw pictures about what do I look like right now? What do I look like when I'm in the middle of an addiction episode? And what do I want to look like if I were free of addiction? And it's one of the most powerful pieces of their intervention because it gives them an opportunity to express in a medium that anybody can use, nobody's grading the art. Things that are not necessarily captured by words, and it doesn't take a lot of time, and it's interesting to see those pictures evolve over time, and it gets at the core of identity and dignity once again, right?

And I think there are many OT clinics that use these modalities. I think we could use them much more. And wouldn't it be interesting to bring some of those into these communities of practice for discussion? How much more would we be able to be present if we were

able to routinely look at the world through the eyes of our clients. And 9 times out of 10, my experience has been that people can't really do that until they're on the other side. Either they or a loved one are experiencing rehab and then their eyes are opened to all the different ways in which we're failing ourselves, failing our clients. Right?

But these expressive modalities are powerful, and they may eliminate the need for that personal experience to better understand how people see the world. I encourage our students to do that. So, they're anxious to get out there and accomplish something, so we have them start a 'good ideas' list and set some goals, and then every 6 months take a look, and knock off the things they got done and didn't even realize they had accomplished. And set new goals and ...document or journal about it. They do it in different ways—some of them write, some of them do it personally on their computer, some of them blog and share it with others, some of them do it daily, some of them do it quarterly; the bottom line is to reflect. We've lost the art of reflection, both within our practice as well as within our own self-help.

Why are different perspectives in the health system so important?

<https://vimeo.com/434031287/b95940f523>

You know, it's a little bit different, but it makes me think of this conversation I recently had with an expert that goes into educational environments and helps scientists, interprofessional team scientists, to generate large research grant applications. And one of the assignments she gives them is, right off the bat, she asked everybody to go around the table and describe attributes of an apple. And they do this and she's like, 'the physicists talk about mass and weights and... somebody talks about the taste and somebody else

talks about the color and other people talk about the shape and other people talk... the nutritional value and other people talk about... the chemical reactions that happen within the apple as it enters your gastric system, you know, just all different ways. And what I thought she was going to say is, because this is a team science exercise right?... the goal is to get everybody talking to each other using the same language, because that's a good application going in, we'll show a consistency of perspective ... And so I said that, and she said, "Oh, no, no, no, no."

The goal is to get them to... recognize each individual perspective in the exercise and recognize that we all come at a simple thing, like describing an apple, with very different viewpoints. And it's harnessing those viewpoints, the similarities and distinctions, that shows the strength of the team, right?

So back to your example of reading a poem, or looking at a piece of art, or reading a chapter, doing a book club, whatever it is, then discussing it and reflecting is not about getting consensus—which is often what we aim for sometimes and maybe inappropriately so—but it is about reflecting and recognizing the strength and expertise of each of those perspectives and broadening our view. Again, community-building, humility-building wisdom. And I do think the health system feels rigid and feels sometimes impenetrable to the humanities. But I think each day we make individual choices how we're going to use the time that we have. And so again, it's just a matter of struggling with [it] a little bit and augmenting how we interact with one another. And that's an easy, tangible thing. You could start tomorrow.

Who have been the mentors in your life and how have they contributed to the person and leader you are today?

<https://vimeo.com/434043553/b4dfc98a9d>

I think I've had a range of mentors in many facets of my life, inside and outside the profession, inside and outside academia. I think the most obvious and most visible mentors were my mentors in occupational therapy, Joan Rogers and Margo Holm, who brought different things to my development. ...Joan is a visionary. Joan thinks in concepts, and she thinks in terms of where we need to be in 10 years. And Margo is very pragmatic. Margo [thinks about], 'how do we get there and what we do today to get us there?' And I benefitted from both of those perspectives immensely. I also benefitted from scientific mentors in geriatric psychiatry, neuropsychology, neurology, epidemiology, clinical trialists, and biostatisticians who taught me how to take big concepts and bring them into testable models. And also, how to communicate, you know, intuitive perspectives within occupational therapy to non-occupational therapy audiences so that people could understand what I was talking about and why it mattered. So, if anything, they taught me how to communicate.

But I think the other thing I learned from many of these individuals is... humility—the value of humility in science in particular. As we seek to uncover knowledge, as we seek to improve our knowledge, we are most successful when you approach it from a perspective of humility, when we don't assume we know the answer. And the unexpected findings are the gems, and the unexplored... experiments. The things that folks maybe don't always think are the most important are often where the great ideas come from. And that requires a level of humility—that's admitting you don't know, that's admitting you could be wrong, and that's admitting that you have something to learn from others or from whatever you're doing.

And that, I think, is the thing that really resonated most with me among my mentors—that level of humility, of... 'we have something to learn here,'— particularly among senior mentors. When I was educating the non-OTs, people not even in rehab, educating them about why what we do matters and why asking these questions is really important and what impact it can have on societal health... [T]his idea of: 'I have everything to learn from you, Beth. So, teach me.' ...It energized me, right? It kept me going despite the necessary rejections and criticisms that this world is full of, right? And I was captivated by that. That's something that I would like to be better at—I would like to improve in—because I think that's the degree to which we keep people energized and engaging in the enterprise.

But I think the same thing is in practice: not assuming that when I sit down with you, having read your medical chart, that I know about you. It's a level of humility. It's, 'You have something to teach me about you that I can learn, that I can then work with you—partner with you—to help you navigate.' And not all left-hemisphere strokes with aphasia and right-sided weakness are the same. Everybody comes with their own story and their own set of circumstances, and people are in the middle of divorces and new marriages, and people are in the middle of retirement and starting their first job, and people are in the middle of strong supportive networks and then they are completely on their own, and they have healthy habits and not-so-healthy habits and it's not a matter of the people who have "A" are going to get a good outcome. It's how do we get everybody to achieve their best outcome?

But I also think I've had a lot of mentors outside the profession, and I think that's been really important. So, even outside of rehab practice, outside of education,

and outside of science, I have these people that are touchpoints, people that I see as sources of wisdom in my life. My mom was certainly one of them before she passed away. But I have these people in my community. Some of them are my church community, and some of them are other folks that I talk through things with, and I get grounded and I rethink things, and they often are gently redirecting me. And I welcome that. I think about, across my life, how many people I have been fortunate to have in my life that do that for me. I just seem to be very fortunate to draw the sources of wisdom, and they're not always likely sources.

But I think maybe if there's a part that I've played in that, [it's] I'm willing to listen. Sometimes it might be the 12-year-old kid you're babysitting that has the great wisdom that day, right? It's just a matter of listening to others. But I do. I have some very good friends at church that I check in with and they know my triggers and then keep an eye on me, and they remind me when I get a little off-kilter. I think having mentors outside of the profession is just as important, if not more important.

About the Author



Dr. Elizabeth Skidmore is Professor and Chair in the Department of Occupational Therapy and Associate Dean of Research at the University of Pittsburgh School of Health and Rehabilitation Sciences. Her research examines interventions that reduce disability and promote participation after brain injury, with a particular focus on giving people with cognitive impairments a voice in the design and implementation of their rehabilitation. Dr. Skidmore believes that the humanities have much to teach us in rehabilitation, a “humanist” profession.



Melissa McCune, PT, DPT, MPH works as a physical therapist at Movement for Life Physical Therapy in Tucson, AZ. She received her Doctor of Physical Therapy and Master of Public Health degrees from Emory University in Atlanta, Georgia and has been engaged with The Journal of Humanities in Rehabilitation since 2018. Melissa was the recipient of the 2019 Frank S. Blanton Humanities in Rehabilitation Scholar award, is an active member of the American Physical Therapy Association (APTA) and strives to regularly contribute research and scholarship to the field. Her clinical interests include geriatrics, women's health, neurological rehabilitation, and population health, and she enjoys working at the intersections of physical therapy, humanities, and public health as a strategy to promote health and well-being across the lifespan. As a clinician, she has grown to recognize the importance of a humanistic approach to patient care as individuals navigate their way through the healing process.