ISSN: 2318-8413 DOI: 10.18554/refacs.v6i1.2379

REFACS
Revista Família, Ciclos de Vida e Saúde no Contexto Social

Occupational therapy in hospital contexts: the specialty, duties, skills and fundamentals

Terapia ocupacional em contextos hospitalares: a especialidade, atribuições, competências e fundamentos

Terapia ocupacional en contextos hospitalarios: la especialidad, atribuciones, competencias y fundamentos

Received: 10/04/2017
Approved: 15/08/2017
Published: 30/03/2018

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It is a reflection that aimed to contextualize the work of occupational therapy in hospital contexts. There are many theoretical references in occupational therapy practice in this field, including the occupational therapy practice framework: domain and process, and Occupational Science or Science of the Occupation. Regardless of the theoretical references that subsidize the professional specialist in hospital contexts, the skills and competencies of the occupational therapist is not restricted to a fragmented vision of knowledge in classic training subspecialties, such as: mental health and physical rehabilitation, since the person care in the process of illness and hospitalization, requires an integral and expanded vision of the individual and their relationship with the occupations in everyday life.
Descriptors: Occupational therapy; Hospital care; Palliative care.

Trata-se de uma reflexão que teve como objetivo contextualizar a atuação da Terapia Ocupacional em contextos hospitalares. Muitos são os referenciais teóricos observados na prática terapêutica ocupacional neste campo, dentre eles destacam-se a estrutura da prática da Terapia Ocupacional: domínio e processo, e a Ciência Ocupacional ou Ciência da Ocupação. Independentemente dos referenciais teóricos que subsidiam a atuação do profissional especialista em contextos hospitalares, espera-se que as habilidades e competências do terapeuta ocupacional não se restrinjam a visão fragmentada do conhecimento em subespecialidades clássicas da formação, tais como: saúde mental e reabilitação física, uma vez que o cuidado à pessoa em processo de adoecimento e hospitalização, exige uma visão integral e ampliada da pessoa e sua relação com as ocupações num cotidiano singular.
Descritores: Terapia ocupacional; Assistência hospitalar; Cuidados paliativos.

Se trata de una reflexión con el objetivo de contextualizar la actuación de la Terapia Ocupacional en contextos hospitalarios. Muchos son los referenciales teóricos observados en la práctica terapéutica ocupacional en este campo, dentro de los que se destacan la estructura de la práctica de la Terapia Ocupacional: dominio y proceso, y la Ciencia Ocupacional o Ciencia de la Ocupación. Independientemente de los referenciales teóricos que subsidian la actuación del profesional especialista en contextos hospitalarios, se espera que las habilidades y competencias del terapeuta ocupacional no se restrinjan a una visión fragmentada del conocimiento en subespecialidades clásicas de la formación, como: salud mental y rehabilitación física, ya que el cuidado a la persona en proceso de enfermedad e intención, exige una visión integral y ampliada de la persona y su relación con las ocupaciones en un cotidiano singular.
Descriptores: Terapia ocupacional; Atención hospitalaria; Cuidados paliativos.

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INTRODUCTION

The creation of the specialties in occupational therapy is a relatively recent fact that dates from the end of the last decade, more precisely in 2009[1].

This scenario, according to some professionals, is a result of the category's mobilization for the needs and realities of the labor market, and consequently, fields and professional skills centers.

This movement has been legitimized by the Federal Council of Physical and Occupational Therapy (COFFITO) in partnership with the Regional Councils and Associations and representative entities of the class, namely Brazilian Association of Occupational Therapists (ABRATO) and Scientific Association in Hospital Contexts and Palliative Care (ATOHOSP). On the other hand, the definition of Occupational Therapy specialties is questioned by many occupational therapists because of the fragmented and reductionist disciplinary reasoning.

The search for legitimacy of fields and areas of competence, and the consolidation of specific/specialized knowledge of the specialties, not always involves the dialogue and reflection with the public policies in health, education, social and culture to work in consonance with the national curriculum guidelines for undergraduate courses that advocates a professional trained to be generalist, humanist and with the fundamentals and principles of the profession. This reality, if not observed with discretion, may result in the fragmentation of knowledge and practices in Occupational Therapy.

The Constitution of the specialties is organized according to a set of interim negotiations, endless, to a certain extent because they are impossible to be refereed by a rationality technic[2]. The definition of these fields depends on political and professionals' broader interests, and not just on the guidelines of each professional category[2].

About the field of Occupational Therapy in hospital contexts, the specialty was recognized in November 06, 2009 by COFFITO Resolution No. 371-06 November 2009[1], which states the amendment of article 1 of COFFITO Resolution No. 366/2009, which did not include such specialty. This document recognizes the specialties in Occupational Therapy: Mental Health; Functional Health; Public Health; Family health; Social Contexts; Hospital Contexts and Acupuncture. However, the specialty become a subject only in July 2013, from the resolution No. 429, which defines the areas of expertise and competencies of the Occupational Therapist specialized in Hospital Contexts[3].

This study aimed to contextualize the work of Occupational Therapy in hospital contexts.

METHOD

It is a reflection on the practice of Occupational Therapy in Hospital Contexts, focusing on the specialty regulations in Brazil, the areas of activity of the professional, and their duties and responsibilities, as well as basics for practice.

We used critical and reflective analysis of the Federal Council of Physical and Occupational Therapy (COFFITO) resolutions, open documents available online (https://www.coffito.gov.br/nsite/) and the specialized literature in the area of Occupational Therapy practice in hospital assistance. The available data were analyzed and based from a literature review.

As a basis, the following questions were used: How is the insertion process of the occupational therapist in hospital assistance currently in Brazil? What does the specialty Occupational Therapy in hospital contexts and palliative care advocates as recommended by COFFITO? What are the practice areas of the Occupational Therapist specialist in Hospital Contexts? What are the assignments and competencies of the professional in this specialty? What foundations subsidize their practice in Hospital Contexts and Palliative Care?

RESULTS

From the questions above and based on related bibliography review on the specialty regulations of Occupational Therapy in

Hospital Contexts and Palliative Care, we created three main themes, namely:
1) "Regulation, assignments, competencies of the Occupational Therapist specialist in Hospital Contexts and Palliative Care";
2) "Basics for Occupational Therapy practice in Hospital Contexts and Palliative Care"; and,
3) "Reflections on the role of Occupational Therapy in Hospital Contexts and Palliative Care".

DISCUSSION

Regulations, assignments, competencies of the Occupational Therapist, specialist in hospital Contexts and Palliative Care

The specialty Hospital Contexts becomes a subject in July 2013, from Resolution No. 429, which defines the areas of expertise and competencies of the occupational therapist specialist in Hospital Contexts[3].

For COFFITO[1], the specialist in Hospital Contexts practice areas are: Intra-hospital, Extra-hospital and Palliative Care. In this sense, the environments considered for specialty practice are: hospitals, clinics (specialized units, clinics, doctors' offices and health centers), patients' house and home care services, which can be public, private, philanthropist, military or third sector.

Interventions in this specialty recommend: occupational therapy diagnosis, choice, execution and use of methods, techniques and resources appropriate and relevant to the hospital contexts, by approaching the individual and collective (client /patient/user, caregivers and groups) at all levels and stages of ontogeny development 1.

Thus, the Resolution provides that the occupational therapist specialist in Hospital Contexts should promote actions of promotion, prevention, protection, education, intervention, recovery, rehabilitation and palliative care, according to principles and guidelines of the health system, about conceptions of completeness and humanization of health care, with emphasis on the care offered in health lines[1].

The assignments exercised by the occupational therapist specialist in Hospital Contexts cover services management, teaching and research, and have the technical responsibility of coordination and supervision, management, direction, leadership, consulting, auditing, expertise, teaching and research[1].

In this sense, the occupational therapist specialist in Hospital Contexts is expected to be able to: conduct consultation, inter-consultation and occupational therapeutic evaluation with patient, client, user, family, caregivers and groups; establish occupational therapeutic diagnosis and if necessary to request inter-consultation, complementary examinations and opinions to define the conduct and the therapeutic-occupational prognosis; carry out the treatment planning and intervention-consisting of a series of actions involving both the selection, and the indication and application of methods, techniques and occupational therapeutic procedures, appropriate and pertinent to the needs and characteristics of the patient/client/family caregivers and user groups, monitoring their performance in different occupational areas[1].

It particularly focuses on daily life activities (DLA's), instrumental activities of daily life (IDLA's), productivity, leisure and social participation; it determines the conditions of high occupational therapeutic and possible referrals; issues reports, attestations, opinions and occupational therapeutic reporting; participates in management agencies, manage technical and administrative areas[1].

Basics for Occupational Therapy practice in Hospital Contexts and Palliative Care

Many theoretical references have been observed in occupational therapeutic practice in this field.

In relation to this issue, the actions of Occupational Therapy should ensure that the subject and their social network are understood and cared through a broader listening to their needs, thus avoiding both theoretical and methodological approaches initially adopted (from the specialty option of occupational therapist), as the most idealized rationales of the health system and less close

to the needs of the users, even considering the hospital as a place for health promotion[4].

Several theoretical references have been used to guide occupational therapeutic practice with hospital contexts and palliative care. Among them, the structure of the practice of Occupational Therapy: domain and process, proposed by the American Occupational Therapy Association (AOTA), 3rd. Edition[5], and this approach may guide the principles and guidelines of resolution No. 429, 2013, which defines the performance of the Occupational Therapist specialist in Hospital Contexts.

AOTA[5] understands that the field of Occupational Therapy aims to support involvement, participation and health. Attention focuses of Occupational Therapy domain are occupations, customer factors, performance skills, performance standards beyond contexts and environments, while the therapeutic process is ordained by means of evaluation, intervention and results monitoring.

Another theoretical reference possible to subsidize practices in Occupational Therapy in Hospital Contexts is the Occupational Science or Science of Occupation that comprises phenomena in a multi-causal and relational conception, considering the interactions as dynamics, by the complexity prism[6], in which occupation is understood as an action that assumes a form and meaning for a person in a certain physical, social, cultural, economic context.

This is an individual and subjective, complex setting that is influenced by several factors that interact in a non-linear and dynamic way.

It is known that the occupational form involves what people do and how it occurs in relation to time and space. It results from the interaction of an activity with the environment in a given time and physical and social space. The form refers to the visible and observable characteristics of an occupation[6,7].

The objective is to understand, what and how people do things? How do they fill their time? In the hospital context and in palliative care, the way in which routine occupations are present may be modified.

Still about the occupation, the International Society of Occupational Scientists[8], believes in the value of the occupation and states that "the occupation encompasses all human activities, whether physical, mental, social and spiritual, being fundamental to their autonomy, health, well-being and justice (p. 2)".

In this sense, occupations are the daily activities of human beings, who have a typical way of occurring in each person's life, adding and anchoring intimate and specific meanings for each person that performs a certain activity, which, in turn, are recognized and organized by people in temporal, cultural and social contexts[8].

Occupations can also be understood as something that can generate negative impacts for the person[9]. In this way, how should it be to occupy or continue the daily occupations, before an illness or in the face of a chronic or evolutionary disease?

There is a need to know the occupation according to the experience of the person who performs it. This indication propels the thinking and the need to understand how people's occupations are or vary according to each time, culture, social environment and moment of each person life, from understanding the form, function and occupational meaning[10].

Thus, it is necessary to examine what human beings do with their time, understand their variation according to the ability of each person, how they organize the activities and their adaptations in the middle, their objectives, what they mean, what value they have, identify how occupations work at a certain time in a person's life, among others. These questions lead to an understanding of an occupational dimension.

The centrality of the engagement of people in occupations and in human life, especially as they relate to the health, well-being and social participation[11].

In this sense, the focus should not be only in the activities themselves, but in the meaning that are assigned to them. The individual must be observed in their context, around their occupations, analyzing the activities and relationships that are

established in the process of creation, adaptation, reconstruction and construction, that is, a being who is occupied in interaction with the contexts.

Reflections on the role of Occupational Therapy in Hospital Contexts and Palliative Care

Regardless of the theoretical references that subsidize the professional specialist in Hospital Contexts and Palliative Care, their skills and competence should not be restricted to a fragmented vision of knowledge in classic subspecialties in Occupational Therapy training, such as mental health and physical rehabilitation.

It is expected the person care in case of illness, hospitalization and eminence of death and its biopsychosocial impact, beyond a model focused on the disease and rescue skills and functions compromised/lost.

The actions to be developed aim at an expanded clinical approach, which is not focused on the disease, the signs and symptoms but in understanding the person in their uniqueness, on the proposition of individual therapeutic projects aimed at autonomy, taking decision and the participation to develop integral and humanized care.

Moreover, it should be able to consider the dimensions of the macro institution hospital about the care process, which requires a positivist, ruling and unique logic, understanding the hospital as a unit of care, inserted in a wider perspective that includes the community and the environment in which the person is located.

The prospect of a work process focused on the expanded clinic allows the expansion of the degree of autonomy and the ability for users to understand and act on themselves and on their lifeworld, since the degree of autonomy is measured by the ability to self-care, to understand about the health/disease process, the ability to use the power and establish commitment and contract with others[12].

Changing the "object" and the "objective" of clinical work will require to change the means of intervention, whether therapeutic or diagnostic. Therapy is not restricted only to drugs and surgery, but to therapeutic resources that add value listening and talking, the power of health education and psychosocial support[12].

In this process, to achieve coverage it is important that each hospital incorporates in their daily life, a continuing education device, which allows to rebuild knowledge and attitudes of most of their workers[13].

One of these resources, from this perspective of care, is the development of Therapeutic Projects. These projects are intended to carry out a revision of the diagnosis, new risk assessment and a redefinition of therapeutic intervention lines, redefining tasks and charges of various specialists[14].

The role of the occupational therapist by the hospital must seek to develop listening and reception to the needs and problems of the subjects under care, shifting the axis of hospital health care, understanding it as a care station[4].

Offering assistance in care lines (for children and adolescents; adult under clinical and surgical care; maternal and child health; people with HIV/AIDS, people with cancer; people in palliative care, among others), practices and knowledge produced by Occupational Therapy can go through itineraries in different lines through the primary, secondary and tertiary assistance, and stopping at various "care stations"[4].

In this perspective, the focus of actions of the occupational therapist at the hospital are the everyday activities. Health care offered by Occupational Therapy is to understand and intervene in demonstrations and discontinuities of everyday life caused by diverse situations of illness at home, hospital, and/or other social and health equipment[4].

This expanded and generalist vision of illness and hospitalization, extended and from a perspective of the biomedical institutional model deconstruction, does not exclude mastery, technical skills related to specific demands of complex and specific clinics, that demand unique looks.

Intensive care units, renal therapy centers, cancer treatment units, Pediatric

units and others, demand knowledge and skills. This reality is an alert to the fact that offer inte-consultation does not guarantee a specific and individualized approach. For this purpose, it is necessary the active and continued participation of the occupational therapist with the team and reference units of the requested area.

Inter-consultation aims to assist professionals from other areas in the diagnosis and treatment of patients with psychosocial problems (emerging emotional situations) and mediate the relationship between those involved in the situation (the health team, patients and relatives), facilitating communication, cooperation and conflicts development[15].

In Brazil, a first study in this field was produced with a psychiatric inter-consultation service in a clinic hospital in the State of São Paulo. The study aimed to identify the reasons for inter-consultation request directed by the psychiatric inter-consultation team targeted for Occupational Therapy assistance. It was evidenced that the main reasons of requests were related to difficulties assigned by the team in relation to the patient, followed by difficulties related to team support[16].

Some of the reasons attributed to patients include: manifestations of psychiatric symptoms, psychosocial/psychotherapy follow-up request; emotional reactions caused by invasive procedures; the psychiatric antecedents, and malfunctions, or physical disabilities.
Psychosocial/psychotherapy follow-up requests referred mainly to people with bad prognosis, in terminal cases[16].

As for reasons related to the team, we observed management difficulties, support request to differential diagnosis and diagnostic research. The resistance to treatment and isolation/restriction to bed were also reasons for inter-consultation request, besides problems caused by extended periods in hospital and ethical dilemmas. The main ethical dilemmas identified were: extra hospital sexual abuse, euthanasia desire, family abandonment and support to communicate diagnostics and difficult news. At the time of this research completion, few were Occupational Therapy practices in General Hospitals with records and related scientific productions[16].

Another study[17] points out that the reasons for inter-consultation request in Occupational Therapy in General Hospital are related to extended periods of hospitalization; facility in clinical management with the patient; expansion of the relational field (patient- family patient-team, patient-patient); and to create conditions to improve and adapt the procedures necessary for patient treatment and hospitalization.

Other research highlights five groups of reasons for inter-consultation request in Occupational Therapy. They are: “hospitalization”, which involves issues related to the difficulty of the patient to adapt to hospital routine, to be hospitalized for a long period and to relate to the team; “idleness”, which consists in confirming patient idleness and the need of occupation; “other”, that includes aid for performing daily life activities (DLAs), Orthotics confections, promotion of neuro psychomotor stimulation and/or Occupational Therapy request by patients who had been admitted before; “emotional aspect of the patient”, i.e. request based on complaints or psychiatric diagnoses (such as sadness, discouragement, depression, anxiety); and “request with no description”[18,19].

As functions of the Inter Consultant Occupational Therapist in general hospital, we stand out: broadening healthy aspects; decreasing disruption and disorganization of everyday life; assisting in the process of deinstitutionalization and reinsertion of the individual; discussing strategies with the requesting team; and guiding the family with the patient care[20].

In the general hospital the person is temporarily without a daily life that may or may not be inserted into a hospital routine[18,19].

To highlight this reflection, there is a difference between routine in the hospital and daily life contexts. Routine is a path already known, a sequence of acts, uses, observed by force of habit, while daily life is every person’s

life, without any exception, whatever their place in the division of intellectual and physical work; and everyday life, is heterogeneous in large part and in many respects, especially about the content and significance of our types of activities[18,21].

Routine is a sequence of acts devoid of meanings while daily life, on the other hand, is constituted by the particularity of the meanings attributed to the actions by the subject[18].

Thus, as daily life is related to social participation, we can think that in the hospital environment, occupational therapists will deal directly with the routine and not with daily life of the individual, but they can provide a living space of new abilities that will help the individual to rebuild, resume or create their daily life, since "(the organization of everyday life) begins as long as a relationship is settled in the transfer, allowing, by building activities, that daily life is meant for the subject in Occupational Therapy".

Another perspective of thinking about daily life in the hospital contexts, arises from the definition of "daily life", as "each day", as the unit of measure of the human lives continuity, made from one day after the other in a fluid, successive and continuous way; besides that daily life includes the individual in their plan of life in common with others, which integrates the individual in the community[22].

Thus, getting sick and being in hospital has a direct relationship in each day living in human life, this experience restricts a life in a fluid, successive and continuous way, limiting and threatening living, at one of the most vulnerable moments of the person's life. It is necessary to rebuild their daily life, even in adverse conditions, where it perpetuates the routine so imposed but necessary to the continuity of life.

From a perspective based on Occupational Science, occupation is limited to occupational therapy, in which the professional performance will base their interventions under human activities and their repercussions in life, leading to a way of dimension, perceive, interpret and intervene with their activities. In this perspective, Occupational Therapy considers occupation as a product and a means of construction of the human being[23].

The aim is to understand the relationships that the person establishes with their condition of life and the occupations, considering them as scientific instruments to understand the human occupation, since the occupations enable the person to be recognized by others and themselves on their doing, allowing to know their life and occupational history and the way they perform activities in the context they are inserted[23].

Depending on how people interact and perceive their daily occupations, they may influence the perception of an occupational and personal identity. These occupations reflect cultural values, provide structures, meanings (the 'whys of an occupation') of the activities that satisfy or not the human needs[11].

The condition of illness and hospitalization can require changes and adaptations in the way they relate, interact with their surroundings by means of their occupations or with the need to rediscover the function and the meaning of feeling capable.

It can lead to review, from the new condition, the skills to perform what gives them pleasure and meaning to their lives.

Occupations before, during and after an illness and hospitalization may be disconnected. Daily functions and occupations can be abruptly altered, and there may be sadness, anguish, feelings of futility and apathy, where the form, sense and meaning of doing something in life may be changed.

Studies have approached beyond the individual experiences. They focused on the factors that influence and determine the participation of people in their occupations, highlighting the positive and negative aspects associated with the involvement and/or deprivation of engagement in these actions. In addition, they also prioritize investigations that reveal these experiences sharing and their repercussions in the community[24-27].

About assistance and care for people in the hospital context and palliative care,

Occupational Therapy objective is to understand how people occupy themselves in the surroundings in which they live, or how the ways of performing activities have influenced or implied in the condition of health, life and participation in the social environment.

Why or what makes people do what they do every day? Do people always perform the occupations they want when they want? And what do people think about their daily occupations? Are they important? Why is that? What meanings they assign to them?

The answers to these questions can help to understand the occupational dimension of people who have their lives and occupations modified because of illness and hospitalization.

Under these conditions, it is necessary to be opened to understand what supports and/or feeds or not the movement and the intention to be occupied every day. It can produce knowledge that reveal the importance of occupations in different contexts of lives, a condition that has influenced the practice of Occupational Therapy.

CONCLUSION

The specialty occupational therapist in hospital contexts and palliative care tries, together with the sick admitted person, to identify facilitators and limiting factors of occupations in this context of life.

Thus, it is important to the professional practice, the construction of singular therapeutic projects together with the multi-professional team.

In the hospital, it is necessary to understand, among other things, how occupations occur? What are the senses and meanings of them? What are the activities they no longer accomplish? What has become routine or habitual in the hospital, and especially, how the person feels and what they realize about the occupations lived in the hospital?

Based on this, the occupational therapist can facilitate the (re) knowledge of the hospital as a belonging place-territory with possibilities, and that the mere repetition of daily actions is illusory, and that daily life presents a transformer potential. The occupational therapeutic process can thus be a catalyst for a consciousness-making that make the person awake to a more full, healthy, creative and life-producing living.

The practice of the occupational therapist may be focused on the possibilities and resources, with a commitment to the potentiation, intensification of life, which allows human exchanges and relationships.

It aims to understand how human occupations can be used to gather and (re) mean fragments of their experiences and transform them into new elements, that enable them to broaden practical and concrete life, and to face hospitalization in a more active and healthy way and/or beyond that.

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CONTRIBUTIONS
Heloísa Cristina Figueiredo Frizzo contributed in the design of the work, the survey data, the analysis and discussion and writing. **Victor Augusto Cavaleiro Corrêa** worked in the design of the work, the survey data, the analysis and discussion and in writing.

How to cite this article (Vancouver)
Frizzo HCF, Corrêa VAC. Occupational therapy in hospital contexts: the specialty, duties, skills and fundamentals. REFACS [Internet]. 2018 [cited in *enter day, month and year access*]; 6(1): 130-139. Available in: *Insert access link*. DOI: *Insert* DOI *link*

How to cite this article (ABNT)
FRIZZO, H. C. F.; CORRÊA, V. A. C. Occupational therapy in hospital contexts: the specialty, duties, skills and fundamentals. **REFACS**, Uberaba, v. 6, n. 1, p. 130-139, 2018. Available at: < *insert access link* >. Access in: *enter day, month and year*. DOI: *Insert* DOI *link*.

Como citar este artigo (APA)
Frizzo, H. C. F. & Corrêa, V. A. C. (2018). Occupational therapy in hospital contexts: the specialty, duties, skills and fundamentals. *REFACS*, 6(1), 130-139. Retrieved on: *enter day, month and year of access of insert link of access*. DOI: *insert* DOI *link*.