Harnessing Human Praxis: Turning our Wisdom into Practice with Impact

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ABSTRACT

Human praxis denotes practical wisdom, which through deliberate human action aims at personal and collective transformation, including people's ideas, commitments and consciousness. The occupational therapy profession has a long history of both enacting human praxis for the evolvement of the profession, and also facilitating it among the people it serves. Occupational therapy can draw on its innate wisdom and ability to accurately read contexts to consciously harness human praxis to render the profession as indispensable as a healthcare profession as well as a profession that can contribute significantly to social development. Consciously harnessing human praxis for change can be done by applying reflective and reflexive critical reasoning; epistemic fluency within multidisciplinary spaces (that could promote better transdisciplinary practices); as well as deconstructing the constituents of human praxis to apply it as a treatment mode. Furthermore, consciously using human praxis can contribute to the fields of education, research and leadership that promote and cultivate human dignity.

INTRODUCTION

The outline for today's lecture is the following. The concept of human praxis will be discussed with examples and its possible relevance for the occupational therapy profession. The possible ways how we can harness human praxis will then be put forward in terms of a) Critical reasoning and the value of Philosophy, b) Epistemic fluency, c) Human praxis as a possible treatment mode. The lecture will then conclude with some reflexive suggestions/thought provocations on making it happen in future regarding education, research, practice and leadership. It is noticeable that there is a semantic tension in today's title. 'Human praxis' signifies a complex and perhaps qualitative connotation, while the word 'impact' suggests a denotation that is more definite and measurable. I hope that the very nature of human praxis and the calls to our profession will underscore this tension comfortably.

One of occupational therapy's roots stems from the first wave of feminism, a small group of women known as the Suffrage Movement. Two women, Jane Addams and Ellen Gates Starr founded the social community settlement in Chicago known as Hull-House and advocated for the health, safety and labour rights of immigrants, who were also often institutionalised and labelled as 'mad' because of not being able to speak the language. Hull-House created spaces for reciprocal, and interdependent relations between people with various identities. Addams was convinced that "society was made stronger through better understanding among diverse people"[1:107-108]. This view of transactional/pragmatic caring[2] was contrarian to the capitalist drive of a second industrial revolution of the day to harness human power for little money for many, and much more money for few. This counter posture to the

social norms of the day not only brought significant changes to the Suffrage Movement but also important changes to the Chicago community they formed part of through e.g. health and protective legislation for juveniles, women and children[3]. Hull-House was a hub where many activities were generated in response to the community members' needs such as social clubs, adult education, parks and recreation programmes and community theatre1.

Fast forward to WWII and the occupational therapy profession, yet to formalise its knowledge base through evidence, its establishment at universities as training programmes reached the South African shores and the first occupational therapy higher education programme of the continent was founded at Wits University in 1943. The profession was such a hot topic of the day that there are anecdotes of people slipping into hospitals as members of staff, pretending to be an occupational therapist[4]! Occupational therapy changed the scene of medical healthcare, elucidating the importance of a holistic view of both patients and their context. However, in the following couple of decades, the profession did so again not only despite, but also because of its response, albeit under duress to the medical fraternity's appeal for scientifically proving its theoretical knowledge base. Thereafter, in the eighties occupational therapy negotiated its second paradigm shift when it was reflexively confronted with the attenuated tenets of a mechanistic paradigm. Following an occupational science symposium in 1988 at the University of Southern California, a call for an occupational science doctoral programme saw the light in 1989 - giving function and form to occupational science as a discipline[5], the mythological birth of a parent discipline borne from the young-adult, applied science.

These are all examples of the occupational therapy profession as a collective enacting praxis. Reflexively responding to context, and actioning for change. And because the profession, in its theoretical roots, understands the importance of context and the associated complexity, it could change it. In its negotiation of two paradigm crises, it did not only show resilience, akin to an elastic stretched and returning to its original form. I would argue that in the vein of Nasim Taleb's[6] work on antifragility, significant growth happens upon disruption, and because of, not despite adversity. It is also within such ruptures where critical turns are possible, where we can acknowledge mistakes, including our boundedness by the historical markers of colonialism[7]. For as Confucius[8] would say, 'To make a mistake and yet not to change your ways, this is what is called truly making a mistake'. Occupational therapy made change matter because it responded to context, perhaps even sometimes acted counter-intuitively, and demonstrated the courage to leap into the unknown, focusing less on personal metrics (an inward gaze) and more on what it can contribute to the greater good, which is an outward gaze[9].

HUMAN PRAXIS

We have asked this question before: "Why do some people with little or no therapeutic intervention after, or during injury, illness or trauma, manage to not only reconfigure their own lives but also exert that change and transformation beyond themselves into the communities they form part of? Think of for example Helen Keller (1880-1968), the iconic scholar, poet, and political activist who was born deaf and blind. Another striking example is the narrative of Zama Mofokeng, 26 years old [in 2021] and who set a Guinness Book record in 2017 and again in 2021, for the most single-hand backflips. He lives in a township in Gauteng, taught himself gymnastics after a car accident and subsequent epilepsy, and set the world record to prove resilience despite epilepsy, and demonstrated to the children in his community that one can overcome challenges[10":11:14] (The video can be accessed here https://youtu.be/eGUOamTekX0)

Human praxis is a dynamic, dialogical and creative process that simultaneously is about being in this world but also being critical of it. Praxis is the practical application of theory, in Aristotle's terms phronesis; practical wisdom, through deliberate human action aimed at personal and collective transformation, including people's ideas, commitments and consciousness.[12,13] Important to note here the constituents of both the individual and the collective, a dichotomy that we often and automatically critique in decolonial work. At the nexus of praxis, is a process by which individuals or groups engage in intentional action to effect change in their own lives and society at large. This committed action is buttressed by an agency in response to constraints; and a perceptive awareness and accurate critical reflection of past and present struggles, as well as possible opportunities for change[11,14]. At the core of human praxis is an openness to learning by doing, including making mistakes and trying again – therefore a process and not a singular event. Do you recognise this process? Have you witnessed it? Or even lived it? I am sure you have…

Human praxis across disciplines

As argued previously, "the concept of human praxis straddles various disciplines and theoretical frameworks such as philosophy, institutional change theory, education, and critical theory[15,16,17,18]. Within organizational change theory, Seo and Creed15 define praxis as collective human action that involves a highly dialectic process in responding to the inertia of the organizational status quo, and the desired changes for the greater good."[11:14] In education, Freire's[14] critical pedagogy argues for the importance of critical reflection and action towards transformation for education to be liberating, and not reproducing encultured patterns of unjust inclusion and exclusion. "Within occupational therapy, praxis is a term that is used in Sensory Integration to denote motor planning in the sense of how to plan, organize and carry out a sequence of unfamiliar actions within one's physical environment; how to do what one intends efficiently[19]." [11:14]. Can you already see the parallel in this definition of sensory praxis with human praxis? South African scholars doing critical work in occupational therapy, put forward evidence of how decolonial praxis can form the centre of community development practice as a pedagogy informing teaching and learning in a Global South contexte.g[20]. Furthermore, how a decolonial perspective in research praxis, "enriches occupational science to re-orient knowledge production away from dominating paradigms, opening opportunities for exploring the plurality and diversity of human occupation"[21:252]. Another example of praxis work explored in South Africa is the paper presented by Dr Adams[22] about the application of the Vona du Toit Model of Creative Ability towards decolonial collective occupation, and how important enabling environments. i.e. contexts, are for cultivating relationships needed for collective occupations.

POSSIBLE STRATEGIES FOR HARNESSING HUMAN PRAXIS

Occupational theory is undergirded by an awareness and understanding of the occupational nature of human beings, the intrinsic link between occupational participation and health, as well as context. Be it the physical environment, historical, cultural, geopolitical, educational, socio-economic, or ecological. We must understand the context if we want to design contextually responsive treatment for our clients/patients.

One strategy could be to with intent, critically reason about what we know, and its relevance in the Global South context. To be contextually responsive, we also need to be critical of the appropriateness or shortcomings of theoretical lenses, evaluating their "ideological and structural contexts"[23:23] and their appropriateness for South African practice contexts. For example, factors associated with the Sustainable Goals of Development, such as employment, gender and education disparities, social status, personal safety across community spaces, and transportation, are imperative considerations in the quest for accurate reflection and applying theory wisely[24].

A second strategy pertains to reading accurately the context of interdisciplinarity, we need to practice epistemic fluency. Reading contexts perceptively may also imply that we need to 'read the professional grid' of accessibility of our professional and research jargon to members of the multi-disciplinary team and, how we communicate in these spaces. An uncomfortable but invaluable lesson I learned some years ago when I delivered a keynote at an interdisciplinary social justice event on critical discourse analysis and archaeology. Using very technical philosophical and Foucauldian terms deemed epistemically inaccessible (see, as I am doing now), many of my interdisciplinary colleagues' epistemic alienation was palpable… And where alienation/exclusion is experienced, often disengagement follows. A third strategy is about the process of human praxis that can serve as a possible treatment mode to consciously facilitate agency and action, which I will discuss briefly later. Let us expand a little on each of the strategies to harness human praxis.

Critical Reasoning and the Value of Philosophy

We all are philosophers

What is the value of philosophy in occupational therapy? Sjo, what a question. Whether we know it or not, each of us here has philosophical underpinnings driving our ways of thinking, speaking, being and becoming. We have a certain way of viewing the world, people and living things in it; and what we regard as a good life. These lenses include the values we underscore about how we view (and think of) people, and how we behave toward people (i.e. ethics). However, knowledge and coming to know, do not happen on our accord only. Knowledge and how we came to know is historical, intergenerational and political – meaning, 'where there is knowledge there is power'[25]. Michel Foucault a prolific philosopher, in dismantling systems of knowledge and how we come to assume taken-for-granted ways of thinking, speaking and doing reminds us (every time I read this quote it is with a sense of such a goodness-of-fit for occupational therapy: "[K]nowledge is always the historical and circumstantial result of conditions outside the domain of knowledge. In reality, knowledge is an event that falls under the category of activity" [26:13]. That means knowledge does not stand alone, waiting to be harvested, but is co-created through many 'rules of formation'. Such as who had a say about why certain knowledge was legitimised, and what types of reasoning were employed to elevate knowledge to a 'thing' of importance, a 'truth'[27].

In many ways, we become what we know. With each "acquisition of knowledge, we change ourselves a little bit. We change what we can do, what we think it is rational to do, what is important to do"[28:1]. Think about how social media has shaped how people decide what is rational and important to do, and how this way of assimilating or "renting knowledge" as Shackell[28] argues, has become akin to what AI is becoming, an astounding reflection of what is going on inside of us, how we articulate or regard humanity.[29]

Reflectivity and reflexivity

Hence it is so important to question our knowing. While questioning things is a human condition (because we are all philosophers), the conscious application of accurate judicious reflective, and reflexive critical thinking is a key element in turning our wisdom into contextually responsive practice that matters. Reflectivity relates to thinking about what one has learnt, and how the learning affects one's actions going forward. (Note the embedded posture here to an openness to see and acknowledge possible mistakes and learn from them). Reflexivity is a deeper reflective process, where one thinks about what one has learnt, and considers the implications thereof not only for oneself but also for the broader context in which one lives and works[30].Reflexivity also means to think and question, one's ways of being in, and seeing the world. For example, could our subjective lenses of interpretation not be one of the reasons models in occupational therapy developed in the Global North are often, though sometimes perhaps unfairly discredited? Many models are about systems e.g. Kielhofner's Model of Human Occupation being a pertinent example, and systems in their structures are often universal[31]. For example, think about occupational science's paradigmatic premise that all human beings are occupational beings. However, how we interpretively use systems models is also bound by subjective context and worldview. Part of reflective and reflexive thinking is therefore intentional critical reasoning.

Purpose and traits of a critical thinker

Critical thinking is the art of analysing and evaluating thought processes (and not people, it is not personal) to improve thinking and reasoning toward better outcomes for everyone. Intellectual traits such as intellectual integrity, intellectual empathy and intellectual humility as well as intellectual confidence distinguish a fair-minded critical thinker who is ethical, empathetic and strives towards justice, from a possible good-hearted but self-deceived person, or, from an unethical, self-righteous and self-deceived critical person[32].

A few key questions for guiding your thinking

So, holding back the occupational therapist in me, it is here where I could have asked you: pick any argument, any belief you feel strongly about. (Be reminded though that a belief is not necessarily true and that the two concepts, an argument and a belief, are not the same.) The background to the skill of good critical reasoning is when people are locked in conflict or have differences in 'opinion', ever so often the default is to jump right into an argument about values, concepts or characteristics, dishing out fallacies such as attacking the personhood of a person. All while skipping a simple but fundamental first question: What are the facts? Here are a few fundamental questions to check your reasoning. Now, often when students and I dialogue about concepts or content, and we arrive at a true understanding; usually simple but elegant, I would joke and say: 'We need to tattoo that on the soles of our feet (so it can leave an imprint of wherever we go)'. These key questions to check for sound reasoning (slightly adapted from Paul & Elder)[32:15] may be well worth being tattooed somewhere, if not ingrained as 'second nature':

a) "What is the purpose of your argument/reasoning? What problem do you want to solve?"
b) What are the facts/evidence/information? (This question should be asked very early on before we make assumptions about what the meaning of concepts is for the person/groups of people we are engaging. This is a very important reflective question since many of us when in an

argument or conflict, rely heavily on our assumptions before going to the facts first Asking questions before making assumptions is a posture that couples well with intellectual humility.)

"What are your assumptions and are they justified?" Equally, "What is your point of view and what are its weaknesses?"

And importantly, "What are the consequences and implications of your reasoning?" This question is a good ethical barometer because it implies also some consequential ethical reasoning.

The importance of sound critical reasoning cannot be overstated. Image thinking is taught as a life skill from primary school, as applied in several West African schools and households with children from a young age[e.g.33]. (See also as an example this gripping narrative about a father conversing with his young son about inevitable congenital blindness, here https://www.ritcsonline.be/video/into-darkness/)

Epistemic fluency: Reading accurately the context of multi-disciplinary towards transdisciplinary spaces

Long ago, when I did an ideology critique of the occupational therapy profession as part of a master's degree I imagined the following: "…if we lived in a world where [occupational therapy] is globally considered as fundamental to the human rights of health and the well-being of all; a world where other disciplines such as the health sciences, political science, anthropology and economics consult the vital discipline of [occupational therapy] to inform their understanding of what humans perceive as meaningful occupation; a reality where, because of these collaborations, [occupational therapy] is in a position to actively contribute to the making of political and administrative decisions that promote occupational justice for all humans"[34:169].

We have argued in the new 6th edition of Crouch and Ahlers Occupational Therapy in Psychiatry and Mental Health that "[w]hile profession-specific technical language and vocabulary are important to develop a professional identity, especially in a young profession such as occupational therapy, profession-specific technical language and vocabulary do not provide access to persons outside the profession to the body of knowledge (or episteme) used in clinical decision-making and clinical reasoning. Thus, for occupational therapy and its practitioners to be recognised as fundamental to achieving occupational justice for all human beings, we must develop epistemic fluency. As early as 1995, epistemic fluency was defined as: 'the ability to identify and use different ways of knowing, to understand their different forms of expression and evaluation, and to take the perspective of others who are operating within a different epistemic framework'[35:40]. An epistemic framework is the way in which professional knowledge and 'ways of knowing about the world,[36:1] is structured or organised. Developing epistemic fluency means that we must understand our own profession's episteme (i.e. knowledge structures and the associated philosophy and practices deriving from it…), as well as being able to identify that there are 'different ways of knowing'[36:1]…. Someone who is epistemically fluent is proficient in 'different ways of knowing about the world'[36:1] and can flexibly move between various types of knowledge, [to] communicate … decisions effectively within the multi-disciplinary team [36,37]. Epistemic fluency thus, amongst others, involves using a common language with other healthcare professionals in the health and social sectors, for example using the knowledge structure of the International Classification of Function, Disability and Health (ICF)"[30:93]. Epistemic fluency is therefore important when working in a bio-medical setting and may be imperative when we work multidisciplinary; and as astutely argued by Dr Romano, 'when assertively knocking at the doors of co-leaders'[38], leading to better transdisciplinary practices. Epistemic fluency may therefore be put forward as another example of practical wisdom where we need to balance our personal metrics (inward gaze) with how we can contribute to the situation and setting (outward gaze) for the greater good of patients.

Human praxis as a potential treatment approach

There are many examples of how human praxis is/can be harnessed in occupational therapy as a treatment mode such as Galvaan and Peters' Occupation-based Community Development Model[39]; how Soeker's Model of Occupational Self-Efficacy can be used for Work Retraining[40], as well how Casteleijn's Activity Participation Outcome Measure (APOM) can be used to measure therapeutic impact[41] . Here is another example of a study by a group of undergraduate students at the UFS highlighting the core constituents of human praxis. They interviewed people and community leaders who enact praxis in urban and peri-rural environments. The findings included that human praxis is a "dynamic, recursive[17,42,43] and two-phase process consisting of initiators and enablers. This process is recursive because both the initiators and the enablers are defined in terms of each other and are therefore interdependent"[11:18]. Figure 1 (below) depicts the process and constituents of initiators and enablers of human praxis.

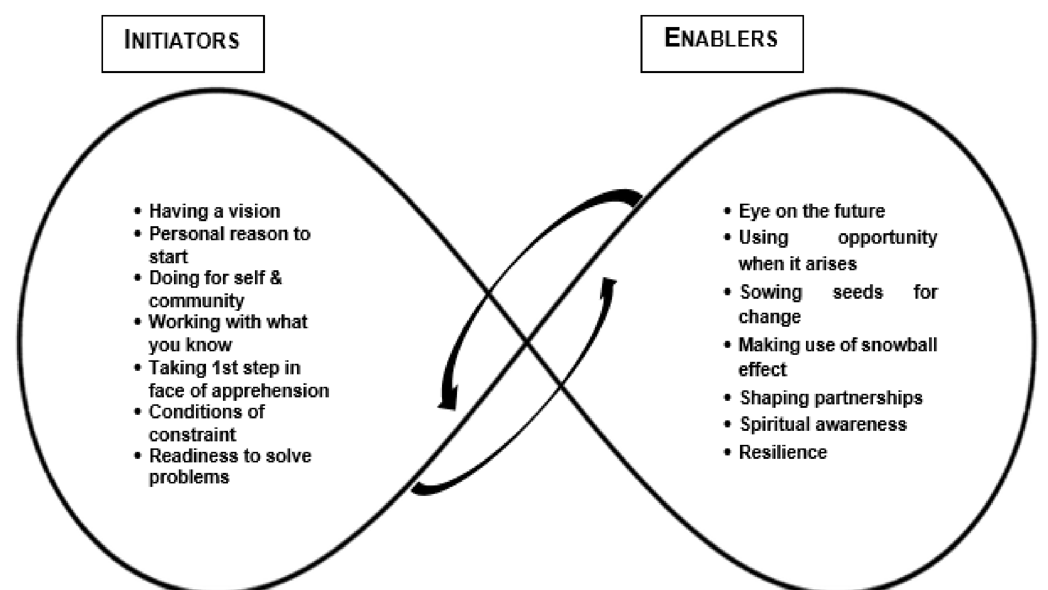

Figure 1. Initiators and enablers of human praxis (Slightly adapted from Rauch vd Merwe et al.[11:16])

To give form to the ideated change, people who enact praxis embrace the importance of shaping partnerships, by sharing their vision that often leads to a snowball effect toward collective change. In this way, a personal responsibility evolves into a shared, and ongoing responsibility because of being aware of and understanding themselves to be part of a whole[44,45,46]. However, central to the mechanisms of human praxis appears to be also the [implicit] conditions of constraint, as an initiator, and resilience as an enabler. It seems that people who enact praxis, consciously anticipate conditions of constraint as well as probable failure with initial attempts. They are however not deterred by it but deliberately use the lessons learned to occupationally adapt toward realizing a solution to occupational challenges[47]. This posture underscores an openness to learning, not taking failures personally or viewing them as defeat, but purposely applying gained insights to grow and develop existing knowings[48,49, 11:18-19]. Here is another audio-visual example of a blind woman enacting praxis. Though the context is within the Global North, the mechanisms are universal. In a colleague's affirming words, 'stories like this remind us of why we

are OTs'. See here
https://www.youtube.com/watch?app=desktop&v=elCqcOUKLpc

MAKING IT HAPPEN

Moving toward the last section of this lecture. How can we then make it happen in various sectors of the occupational therapy practice?

Education

Making a full circle on what it means to know, and then what it means to teach what we know. Foucault,[27] among many other critical philosophers on coloniality and epistemic oppression (e.g. Said50, Mignolo[51], Mbembe[52], Ndlovu-Gatsheni[53]) have argued in the vein of coloniality and oppression that the Western world tends to conquer in order to come to know. So, to know about the 'other', these 'others'/the 'deviant' must be marginalised and suppressed so they can be studied. Much critical literature has been written about these origins of knowledge e.g. about psychiatry, and anthropology[e.g.54].

I too did a critical analysis of the historical markers that formed part of occupational therapy's fraught origin of the profession – we had to fight hard for legitimacy. The study was a theoretical analysis of what we already know in our continuous quest to disrupt unjust historical patterns of inclusion and exclusion in curriculum, and service delivery for example, along our historical societal fault lines of race, gender and class[55]. However, I have since also started questioning the premise of how a body of knowledge, a discipline, in our case a profession, has been formed through the a priori suppression in order to know, as a given rule. As perhaps that is not the case of occupational therapy. Historically, the origin of the occupational therapy profession is built on the strive for inclusion. Inclusion of humanistic values, diverse identities, diverse contexts and diverse occupational needs.

Yet, in many universities and practices, our knowledge is organised in the same way that knowledge about medicine is organised, linear, and compartmentalized to understand. Perhaps underlining the profession's continuous struggle to straddle the knowledge worlds of categorising to control, vis-à-vis including to create, we need to demonstrate our aptness when we move between the worlds of natural and social sciences. What would happen if we organise knowledge differently in curricula closer to the structure representing systems and their complexity? In a very appreciated mentor, Professor Teresa Lorenzo's words: imagine what can happen when we organise the curriculum in terms of child development; life as an adolescent and adult with all its concomitant intricacies of having to negotiate life in South African contexts. Contexts that include poverty and unemployment; violence; and intergenerational trauma. Additionally, skills are needed to imagine a collective occupational future in a democracy as responsible citizens who think critically with effect, and who are praxis enablers. What if we would further organise our curriculum in terms of family life, and work, including 'ethical entrepreneurship' (in Ramano's[38] words) and the occupation of self-employment[56]. Adding a module on intergenerational dynamics and wisdom with a strong focus on occupational performance as the latter is irrevocably linked with a person's context[57]. What will happen if we ask students what do they want to know about a certain exit-level outcome? And let them take agency in choosing literature and constructing learning outcomes and objectives? These suggestions are merely meant to be illustrative alternative ideations, keeping in mind that one of the major calls for occupational therapy is rehabilitation against the backdrop of the WHO 2030 rehabilitation framework[58].

However, on a critical note, neoliberalism is also a global and dominant discourse of our time. It is deeply anchored in capitalism and interprets everything through a lens that translates all ways of being, experiences, education, and relationships into a potential market value or value for the self and proximity partners only, i.e. a mindset underlined by a maxim: 'more for myself and few people close to me, that can repay the favours'. Neoliberalism underscores economic deregulation, privatisation, inequality; shifting responsibility from government to citizens and normalises mindsets of individualism - stopping short of agency for the greater good. Neoliberalism encourages consumerism and (inter alia monetary and status) competitiveness. It does not seek interdependence, (including with the planet we inhabit), pluriversality, or inclusion for the sake of expanding and strengthening the collective for the greater goode.g.[59,60].

This discourse must be countered critically, intellectually and in practice. For example, in the ways we teach and assess students, urging us to revisit the question: what does contextually responsive assessment look like? What role can accrual play in assessment? Do our students have enough time to integrate knowledge before someone is breathing over their shoulder for a mark? How conducive are such practices to the cultivation of life-long learning? And is it time to rethink the curriculum beyond the HPCSA minimum standards of education?

Research

Occupational therapy in its origin and roots of how it views reality (ontology) comfortably straddles both nature and social sciences. It seems qualitative research comes naturally because it is in its nature divergent and generates more questions and possibilities. However, part of 'reading the grid' accurately, means when we are operating in the context of the bio-medical model: and we have to 'walk the talk'. Therefore, the first point is that we all know high-level evidence is imperative in research. Already there are several papers presented at this conference that illustrated that studies need not necessarily be large to be significant[57].

Secondly, regarding intra and interdisciplinary collaboration in research. Perhaps a large challenge is moving our often very heavily invested gaze from undergraduate teaching and learning to a more balanced gaze of research to find the time to think strategically, design larger group research protocols, and cultivate interdisciplinary partners in designing interdisciplinary research projects that are contextually responsive to needs in clinical practice. Another investment that will take time is to find ways in higher education and practice to consolidate information about available grants.

Thirdly, we need to enhance our research education and supervision for both students and supervisors. Universities have been under growing pressure to increase the intake and timely graduation of postgraduate students and postgraduate students61. This is important because postgraduates contribute to knowledge and economic and societal capital. However, with this increase in postgraduate students in the past 10 years, ensuing is also a significant disjoint between the number of available supervisors vis-à-vis postgraduate students, with direct secondary effects, such as low, or poor timeous throughput; in turn bearing significant economic and psychological consequences. Academics feel overloaded and overwhelmed. Students feel isolated, and not sufficiently supervised. Both parties feel unheard[62,63].

There is a substantial argument that dyadic supervision only (also known as the master-apprentice supervision model) is no longer sustainable. We need to enact praxis to incorporate alternative

models including cohort supervision. This a supervision model (there are several variations thereof) draws on collectivism, where not all the responsibility is on one supervisor, and where students can tap into an array of collective sources including learning from each other. A cohort supervision model may open possibilities of a community of practice for supervisors also, where skills in supervision e.g. rigorous research methodologies such as systematic and scoping reviews, and meta-analyses, can be exchanged.

Perhaps following the rethinking of our research education and supervision strategies would be to also think strategically about the output of research as process and product. Research matters mostly when it is out there, to be accessed and read. How can we realise publications with all stakeholders? What kind of outputs are important and who are the audiences it needs to reach? Concerning methodology, design research enables us to put forward a product: whether a framework or guidelines for practice or a contextually relevant part of the curriculum.

Fourthly, we need to create a collective research culture. We need to continue striving to bridge the academic-clinical//theory-practice divide in order to contextually respond to the needs of the societies we are serving. Very fruitful collaborations and outcomes have been generated between academia and clinical practice, where the iteration between theory and practice can be 'praxised' through collaborative research workshops, projects, and expanding fieldwork clinical training sites that are not limited to public institutions. Structurally, it could mean that both education and practice departments prioritise regular collective engagement spaces in their calendars, where everyone can share what they are busy with, what they are wondering about and perhaps where students can present their work followed by debate and discussions.

Sixth, praxis in research can be achieved through learning about and innovatively using technology such as telehealth and other digital interventions. Researching the effectiveness of telehealth and the ethical use of digital interventions can provide much-needed evidence on the challenges and opportunities of technologically innovative practice. One example is van Stormbroek et al.'s[64] study on the value of a virtual community of practice for novice occupational therapists enhancing and exchanging knowledge in hand therapy. Furthermore, referring to the 1st OTASA Congress Keynote by Dr Karen Jacobs "Guiding the Way: Navigating Artificial Intelligence in Occupational Therapy", we can only mention the possibilities which are rapidly emerging in the responsible and highly efficient use of generative AI for example, literature review and data analysis.

Practice and Leadership

The NHI Bill has been signed into law. We must put forward our readiness for it and recognise the opportunities to enact praxis through ideating a vision, generating evidence as to why occupational therapy is indispensable, and shaping partnerships through collaboration. We can also enhance partnerships through consciously practising epistemic fluency by for example using ICF language when engaging with a multidisciplinary team. We can do that without sacrificing intellectual confidence and assertiveness[32]. Finally, with regards to leadership, in honouring our praxis roots in humanism and human dignity, Hicks's[65:16-17] model and well-developed theory of leading with dignity, provide exemplary guidelines (10 elements) for cultivating human dignity in all realms of our practice, being clinical practice, education, or managerial and leadership positions:

1) Embracing Identity: Approach individuals as equals, allowing them to express their true selves without fear of negative judgment. Engage without bias, recognizing that attributes such as race, religion, gender, class, sexual orientation, age, and disability are fundamental tenets of various identities.
2) Recognition: Acknowledge and appreciate colleagues and patients for their talents and hard work. Be generous with praise and give credit for their strengths.
3) Acknowledgment: Show people that they have your full attention by actively listening, validating their experiences and replying to their worries.
4) Inclusion: Ensure that everyone feels a sense of belonging, whether being part of a community, a team, organisation or a fellow human being.
5) Safety: Create an environment where people feel psychologically safe, in the sense of feeling free to share ideas and thoughts without reprisal or humiliation. This element supports the importance of open communication channels.
6) Fairness: Treat everyone justly and equally, following for example previously established and agreed-upon rules, guidelines and policies.
7) Independence: Facilitate individuals to exercise autonomy, fostering a sense of agency and cultivating hope and possibility.
8) Understanding: Value others' thoughts and perspectives by creating space to explain their viewpoints and actively listening to understand them. These are also the tenets of honouring epistemic justice66 and affirming a person's humanity through acknowledging his/her/their epistemic virtue53.
9) Benefit of the doubt: Approach people with a baseline posture of unconditional positive regard and as if they are dependable and trustworthy.
10) Personal accountability: Own your actions (we all make mistakes), apologize if you have compromised another person's dignity, and commit to doing better.

CONCLUSION

Human praxis is part of occupational therapy's history and makeup in fusing the synergy between individual and collective action. We have changed contexts because we understand them well in the many various roles we can assume as clinicians; knowledge workers/thinkers (students, researchers); educators/mentors; community facilitators and advocates. How we made that happen – changing contexts, while upholding values of humanism, interdependence including our planet, and promoting human dignity mattered. We will continue to be context-changers in healthcare in the arenas of education, research, and practice and leadership. We can harness deliberate human praxis drawing on our inherent wisdom by using tools such as critical reasoning skills with intent, reading the contexts in which work accurately and applying epistemic fluency aptly, and facilitating the constituents of human praxis as a treatment mode in ideating change for the greater good. Thank you for listening and sharing this day together.

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