The Issue Is

Should We Trade Person-Centered Service for a Consumer-Based Model?

We owe Bowen (1996) a debt. Her question, "Should occupational therapy adopt a consumer-based model of service delivery [for the sake of increased collaboration with patients]" (p. 899), warrants deep consideration. The question presses past semantics to challenge the ethos of our profession. It is thus, for me, a question of substance.

My inquiries into the nature of the patient-therapist relationship, the history of service in our profession, the nature and demise of moral treatment, the character of occupational therapy, the arc of practice, the fullness of empathy in occupational therapy, the climate of caring, and the factors that can depersonalize practice have introduced me to a heritage that transcends the best of consumer-based models. I fear—Bowen's (1996) aim to empower persons notwithstanding—that occupational therapy would languish if regard for persons were traded for deference to their claims as consumers. The adoption of a consumer-based model poses such a risk. Let me explain.

Terms, Arguments, and Questions

I will share my sense of what it means to adopt a consumer-based model as I iterate my grasp of Bowen's (1996) argument. I choose Reed's (1984) definition of a model as "a physical or symbolic representation of an object or idea" (p. 1). I also know that the term consumer is commonly understood as "a person or thing that consumes, a person who buys goods or services for personal needs...as opposed to a producer" (Webster's New World Dictionary, 1994).

Given these definitions, I hear Bowen's (1996) argument thus: Practitioners should symbolically represent the persons whom they serve as consumers. The symbolic idea (metaphor) of consumer can infuse practice with the directive to respect the autonomy of those who seek therapy. A consumer-based model can center service on the will of the person being served; practitioners guided by this model will collaborate and thus "ensure that the consumer is autonomous in establishing treatment plans and goals" (p. 900).

Before turning to Bowen's (1996) argument, I must speak to her semantics. The personal agency that she proposed is not well conveyed by the idea of consumer—one who buys from another who produces. Collaboration, defined as "working together" (Webster's New World Dictionary, 1994), seems better served by other metaphors. When Reed (1984) discussed the utility of models for practice, she noted the drawback of "inaccurate representation" (p. 4) in which the symbol chosen does not match what it aims to symbolize. I see this lack of match in the suggestion that we adopt a model on the basis of an idea of persons whom we serve as consumers; consumer conveys an agency that falls short of collaboration.

Bowen's (1996) equated a consumer-based model with client-centered practice; I do not. The terms client and patients share more similarity in meaning than either does with the term consumer. The term client, commonly defined as a "person dependent on another, as for protection or patronage...a person served by a social agency," derives from a root (clinere) that means to lean on another. The term patient, a "person receiving care or treatment," comes from the root word for suffering (pall) (Webster's New World Dictionary, 1994). Symbolically, patients and clients evoke from most a disposition to care; consumers do not.

Bowen's (1996) equation of client-centered service and consumer-based model makes her argument less clear. In a concept paper published in 1995, the profession endorsed client-centered service and deemed collaborative actions important, stating:

The American Occupational Therapy Association (AOTA) asserts that service delivery is client centered and interactive in nature, and that it must be consistent with occupational therapy’s philosophical base (AOTA, 1979), core values and beliefs (AOTA, 1993a), principles of theory and practice, and code of ethics (AOTA, 1994a). (AOTA, 1995, p. 1029)

If Bowen gave the terms client-centered and consumer-based the same meaning, I wonder what further support she sought?

My issue is more than semantics. One problem that we have had in disregarding personal agency stems in part from our having represented persons as patients or clients while practicing within medical or civil agency models. Whenever we ignore the autonomy of "patients who suffer" or "clients who
depend on us,” we neglect the will and courage that dwell alongside the suffering or dependency. Representing persons as consumers will not lessen that neglect; greater risk attends a consumer-based model. If in patterning ourselves after physicians or civil servants we lose our focus on the fullness of persons, we risk more by emulating producers. I prefer the term person (an individual man, woman, or child) when discussing those whom we serve for the full regard that it implies. The term person predates the others and keeps my focus clear (Webster’s New World Dictionary, 1994).

Because Bowen (1996) supported collaboration as a feature of a consumer-based model, I shall press past semantics and turn to her argument with these questions: (a) Does a consumer-based model support collaborative actions? (b) Does our profession’s ethos do so? (c) What help can we gain from a consumer-based model? My questions do not argue against collaboration; they enact Bowen’s hope: “A necessary first step is a thorough discussion of the model and its implications on practice.” (p. 901).

An analogy may set my tone. If my nephew were to ask what I thought of his dressing like a favored jazz musician, I could readily respond after seeing the man’s style. If my nephew were to ask what I thought of his adopting the jazz musician as his model, I would have him tell me more. From the phrase “adopt as a model,” I would gather that he hoped to emulate the salient traits of the musician and perhaps the man. This second question would be more serious and our discussion more extended; my nephew would be asking me about how he should be. Bowen’s (1996) question is similar; she speaks to the character of occupational therapy when she asks us to adopt a consumer-based model. To name the persons who seek our therapy consumers is to frame a response we must consider.

The Ethos of Consumerism: An Impoverishment of Persons

Elsewhere I have argued that good business practices are part of good care (Peloquin, 1996). Occupational therapists must be good managers, accountable, and responsible for service. It makes sense to examine a business model that might place persons at the center of service and make them primary agents. A closer look at the ethos of consumer-based actions will advance my conclusion: We ought nor adopt a consumer-based model.

Shaped by its distinguishing beliefs and values, the ethos of any group is variously known as its disposition or character (Webster’s New World Dictionary, 1994). One way to grasp the ethos of a service is to ask, “For the sake of what and whom does this group do what it does?” For whose sake do producers choose consumer-based actions? In their book, In Search of Excellence—Lessons From America’s Best-Run Companies, Peters and Waterman (1982) discussed the act of “staying close to the customer” (p. 157):

In observing the excellent companies, and specifically the way they interact with customers, what we found most striking was the consistent presence of obsession. This characteristically occurred as a seemingly unjustifiable overcommitment to some form of quality, reliability, or service. (p. 157)

A consumer-based model can prompt good quality, reliability, and service. But intent is important here because I speak of ethos. Peters and Waterman shared this rationale for staying close: “Service, quality, and reliability are strategies aimed at loyalty and long-term revenue stream growth.” (p. 157). If given voice, the ethos prompting the act would say, “Stay close to the consumer because of the sale.”

My concern should be growing clear. Consumer-based actions flow from an ethos of profit, mainly that of the producer: “All business success rests on something labeled a sale, which at least momentarily weds company and customer” (Peters & Waterman, 1982, p. 155). Business experts note that if the aim of customer satisfaction is so obvious as to not need discussion, “despite all the lip service given to the market orientation… the customer is either ignored or considered a bloody nuisance” (Peters & Waterman, 1982, p. 156).

Staying close to the customer is a slippery task. As a consumer, I have often been discounted. Although a small woman, I buy products designed for larger persons. Rarely have I been invited to collaborate with the producers of goods and services despite an assertive business manner (developed in self-defense). I cannot even say that I always choose to buy what I do. Automobile air bags, for example, designed and tested on 70-kilogram men and made mandatory features on my car—for the sake of safety—were only lately deemed life-threatening to persons my size. Collaborative experiences seem reserved for a discrete group whose high income (and thus potential to give real profit) allows custom-made production and unlimited choice. The slogan “buyer beware” conveys the lesser status that spawned advocacy groups and the Consumer Bill of Rights.

In health care delivery, consumerism is an issue. I have examined hundreds of stories of health care gone awry, hoping to learn more about the forces that shape what patients call depersonalization (Peloquin, 1993a). In most instances, some diminished regard for persons (with thoughts and will, feelings and courage, knowledge and understanding, energy and experiences) seemed problematic. Three situations featured foremost in health care fiascoes. The first was when practitioners engaged in a rational fixing of a health care problem, while disregarding a person’s sense of being ill. The second was when practitioners relied overly much on method or protocol, while disregarding a person’s will. The third was when practitioners seemed driven by efficiency and profit. In each instance, caregivers, including occupational therapists, disregarded some vital part of persons (Peloquin, 1993b).

From many such stories, I learned the ethos of a consumer-based model:

Within a business orientation to health care, knowledge takes coin value, cure becomes a high-priced commodity, and ill persons are transformed into buyers. Success and solvency turn into treatment goals, productivity and efficiency into the means to achieve them. In this scheme, more accrues from procedures that cure than from manners that care. (Peloquin, 1993b, p. 940)

When high regard falls to those who treat more patients or tally more billable...
units of time, moments spent noticing, listening, or communicating—the heart of collaboration—are hard to justify. Competition grows between a person’s need for attention and an institution’s need to prosper. When patients see cuts in caring, they feel impoverished. They learn the ethos of this model: Profit holds primary agency, not the person. Depersonalization dominates practice, not collaboration.

**An Ethos Already in Place: For the Sake of Persons**

The ethos of occupational therapy, articulated in the profession’s literature and guiding documents, supports collaboration for the sake of persons and their occupational natures. The founders of the Society for the Promotion of Occupational Therapy established its personal character. Speaking to a group of graduating students, Kidner (1929) noted the profession’s ethos and the effects of losing it:

> May you realize in increasing measure the value of certain spiritual things which are the real making of life, but which we call by many common names, Kindness, humanity, decency, honor, good faith—to give these up under any circumstances whatever would be a loss greater than any defeat, or even death itself. (p. 385)

Within *The Healing Heart*, a biography of Ora Ruggles who was a reconstruction aide during World War I and therapist through the 1950s, we see how this ethos shaped the actions that characterized occupational therapy (Carlova & Ruggles, 1946). Ruggles was disposed to be a covenanted partner—a friend—to her patients (Peloquin, 1993a, 1993b). With occupation and its analysis, she enacted empathy in its fullness, not just as a cognitive grasp of patients’ situations, but as an affective responsibility to their wants and needs (Peloquin, 1995). The title of Ruggles’s biography refers to her discovery: “It is not enough to give a patient something to do with his [her] hands. You must reach for the heart as well as the hands. It’s the heart that really does the healing” (Carlova & Ruggles, 1946, p. 69). Commonly associated with soul, heart includes a person’s passions, energy, courage, and will (Webster’s New World Dictionary, 1994). The ethos of a service that reaches for (and with) the heart fills the first line of the Pledge and Creed for Occupational Therapists submitted by the Boston School of Occupational Therapy and adopted by the Association in 1926: “Reverently and earnestly do I pledge my whole-hearted service” (as cited in Welles, 1976, p. 45). There is no stronger endorsement of collaboration with others than the concept of reaching for their hearts.

The story of Ruggles is not singular. Within the professional literature is a history of therapists striving to practice the science as well as the art, to ensure that the three agents of service—the person who seeks therapy, the occupation, the therapist—come together to make therapy happen (Peloquin, 1989, 1990, 1994, 1995). Within phenomenological narratives and fictional creations, one finds therapists engaged in competent functions alongside caring actions, sometimes falling short of a balance to seem either paternalistic or procedural but as often emerging as covenanted partners, friends, and collaborators (Peloquin, 1990, 1993a). These latter emerge as persons who know what to do while understanding how to be, who tap the courage and will of others, and who see in each relationship a chance to make real and meaningful connections.

If these stories tell the individual strivings of practitioners, they also show our collective aims (Peloquin, 1990, 1993b). The profession’s grasp of its ethos is clear; support has come through events and documents. For example, at a time when therapists seemed skewed toward procedural success, professional leaders issued this call: “A climate of caring is vital and collaboration with patients essential” (Bowen & Yerxa, 1980). The code of ethics supports therapeutic actions, including collaboration for the sake of personal beneficence, autonomy, privacy, confidentiality, duty, justice, fidelity, and veracity (AOTA, 1994). The profession’s newly developed document on core values and attitudes charges therapists to practice the ethos: “The values of altruism, equality, freedom, justice, dignity, truth, and prudence” (AOTA, 1993). The concept paper mentioned at the start of this discussion stated that “service delivery involves the occupational therapy practitioner and client in a collaborative process of working together to design and implement services” (AOTA, 1995, p. 1029). This theme of actively working together (co-laboring) weaves so solidly through the profession’s literature that it is a mandate. We are remiss, as Bowen (1996) suggested, in asking so little about how well we follow it.

**Collaboration: Enacting the Profession’s Ethos**

If the call to collaborate is clear, the need to muster energy for that action is real. A practitioner who hopes to enact our ethos within contexts that tout other values must find support from many sources. For example, concerned years ago about a growing apathy among one group of patients, I worked to help them see the possibilities of occupation (Peloquin, 1983). I found support for this action in Bloomer’s (1978) discussion of the right of “the consumer of therapy” (p. 621) to be informed. I argued that as service providers, we must share our knowledge and give choices accorded in the Consumer Bill of Rights (Bloomer, 1978).

*Years later,* I reviewed a sampling of the occupational therapy literature for evidence of therapists collaborating with patients (Peloquin, 1988). When Bowen did so more recently, she concluded that the “literature in the United States provides little evidence of therapist–consumer collaboration in treatment planning” (Bowen, 1996, p. 900). Because I had thought the term collaboration new in therapeutic circles, I searched for evidence of the process described as active participation and interaction, and I found it.

Comments such as those from Edgerton (1947), McNary (1947), and Wade (1947) supported the patient’s active participation in shaping the treatment plan. These included a call for such involvement even among patients whose impairments might thwart the process. I found more evidence in later literature, such as the work of Fine and Schwimmer (1986) who advocated “the patient’s active participation in setting and evaluating treatment goals” (p. 3). Heartened by this legacy, I developed
ways of moving toward collaboration in an acute psychiatric hospital. Newly aware of the literature, I argued that “even before the emergence of current trends [such as the Consumer Bill of Rights], traditional occupational therapy assumptions supportive of the collaborative approach were well represented in the literature” (Peloquin, 1988, p. 777). My naivety had given way to respect for our ethos.

Practitioners can gain support from contemporary trends (as I did from the Consumer Bill of Rights). New models and current trends can rouse dormant sensibilities and restore energy for enduring tasks. Bowen’s (1996) inquiry into the merits of adopting a consumer-based model can hone our commitment to collaborate. It ought not, however, dull our vision of person-centered care.

**Conclusion**

The question that prompted this discussion was whether we should adopt a consumer-based model of service delivery. I believe that we should not. The prompt to “stay close to the customer” is fine, and it may well move us to collaborate in ways that Bowen (1996) proposed. But the consumer-based model differs from the prompt. We must be wary of adopting a model that grounds collaboration on a pinched ethos of staying close for the sake of profit. The richer ethos of occupational therapy—that we reach for hearts—ought not be traded.

I hope that we will each answer affirmatively Bowen’s (1996) more fundamental question about whether we should collaborate with those whom we serve. We have a longstanding call to do so for the sake of persons and their occupational natures. On occasion, we may renew our energy for the task by citing contemporary trends and models that prompt good actions. But newer is not always better. And collaboration is not the core of consumerism. The values that drive this model can lead to actions not in character with occupational therapy.

We can take heart for collaborating from a longstanding ethos that disposal us to do so: To treat persons with kindness, humanity, decency, honor, and good faith. A consumer-based model can give no such heart. To represent those who seek our service as consumers is to risk a “loss greater than any defeat” (Kidder, 1929, p. 385). Occupational therapy would languish if its ethos—regard for persons—were traded for deference to their claims as consumers. ▲

**References**


Spackman (Eds.), *Occupational therapy* (pp. 40–59). Philadelphia: Lippincott.

