THE ISSUE IS

The Importance of the Client versus Patient Issue for Occupational Therapy

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The tendency for our official language to refer to an occupational therapy client rather than an occupational therapy patient reached a public consensus by 1983, and this shift from a patient-based to a client-based service reflects more than a mere name change. The tone, style, and quality of occupational therapy is being transformed as powerful ethical, legal, and economic forces reshape the practice, administration, education, and research of the discipline. The real significance of change to a client service is that somewhere, at some level, a decision has been made that changes the purpose of occupational therapy service.

In the history of our discipline there is probably no more important policy decision than this one, which changes the focus of service from patient to client. The astounding aspect of the decision is not that it was made, but that it was made outside the awareness of most of the membership. Because this policy forces a radical transformation of the nature of occupational therapy, it threatens their own and their discipline's survival. It is both an individual and national association shame that occupational therapists do not seem to know how and when to engage in a public debate on an issue so critical to the membership and the society in which the service is embedded.

Public Good versus a Discipline's Interest

Survival of a science, a profession, or any discipline is not a given. Society requires each social institution to serve some vital need that is necessary for its culture or civilization. These institutions, so purposed, are kept on trial by society. If expected benefits are not delivered, new institutions are born as old institutions die. Each generation of practitioners in every discipline must renew the contract for services the discipline makes with society. In the many policy transactions disciplines make, a sense of public good may be clearly envisioned or diminished. If public policy or public good is no longer translated by a discipline's policy, then society can be quite punishing. When contracts made for public good are breached by indifference and self-interest, society eventually ceases to reward the aspirations of that selfish discipline.

A case in point is the American health system, which is dominated by policies internal to the American Medical Association (AMA). Many of the policies of the physician service have had a destructive effect, not only on the public good, but on occupational therapy service. The self-interest of medicine is evident in the extensive, exotic services to the few; the indifference in investing in a support system for the chronically ill; and the preemptive use of the medical dollar for drug and surgical treatments at the expense of nursing, rehabilitation, and prevention services. Society expects medicine to adhere to its contract to treat the ill, but knows the contract is breached when the service, by internal policy, excludes by class or diagnosis on the basis of self-interest. In a democratic society, the values of equality and justice do not permit an institution to exclude those who need the service. Failure of physician leadership to adjust policies for the public good, in the long run, is both a political and economic mistake. Physicians, because of their parochial preoccupations, court the political threat of socialized medicine and the economic threat of fee restriction. The issue turns on the Justice Holmes' decree that the power granted to regulate within a public service discipline does not include the power to prohibit the service.

On a smaller scale, but in a no less important way, occupational therapists have some things to learn from the physician service example. We should be forewarned to recognize the need for open and serious discussion about the patient-to-client shift. The dialogue should revolve around the following critical questions:

1. Does the occupational therapy leadership have an internal sense of the membership intent along with an external sense of public good? Were both considered in the policy decision?
The Ethical Issue

In common speech, ethics means a set of moral principles or values that guides behavior. Thus, ethical behavior is whatever behavior conforms to these values. Paradoxically, while a challenge to values may be clear, the nature of ethics remains unclear. Conflict serves the critical function of reducing the ambiguity of the values held. Open, public argument, therefore, is essential in any moral dilemma.

For social institutions such as occupational therapy, ethics has a more formal meaning. Whatever the values and principles the discipline holds, they require justification, which is an attempt to draw a straight line from the purpose of the service to the values the practitioners and leaders should adopt. The process of justification links ethics to purpose. When an individual or a group violates values connected with the purpose or nature of the service, the behavior can be called unethical. In this sense, a policy can be viewed as ethical or unethical.

Reciprocity. It is customary in ethics to discuss the connection between purpose and values in terms of reciprocity. The body of knowledge in any discipline—that is, the reflective concepts and the action of technology—is derived from its reciprocal relationship to the purpose of the services. To illustrate the function of reciprocity, I will draw on my personal experience in developing the occupational behavior framework.

Principles of occupational behavior were drawn by observing the daily living incompetency experienced by permanently disabled patients. Diminished skills and habits were found to permeate all the social role structures, even though the loss was acquired in the illness role. Illness-induced incompetency, therefore, has been the essential focus of occupational behavior. The application of occupational behavior knowledge was seen to provide a public good benefiting both the individual and society. First, providing a treatment system to restore daily living skills and habits is an obvious good because it results in the improved quality of life for the individual. Second, in a less obvious but still valuable way, there is a benefit to the family, school, industry, and other social institutions where patients live. The function of any institution is improved when a member is helped to be less dependent and more productive.

The core beliefs of occupational behavior are shattered for me when illness-induced behavior was shifted to client behavior. I had a déjà vu reaction to the shift that was similar to the famous aphorism on the nature of a vacuum made by Gertrude Stein: “Once, I went to Oakland, and there was no there there.” For me there is no longer any “there there” in occupational therapy for occupational behavior. In the fragmentation of the reciprocity between knowledge and purpose my commitment to the occupational therapy service was shattered.

Effects of Moving Away from Ethics. It is my conviction that moving away from the ethics of a patient service will have two debilitating effects. First, the power of the service to change individual behavior will weaken. The linkage of old knowledge to new problems will be disrupted. Consequently, the old wisdom of our historical clinical experience will not permeate new technology.

Second, the visibility of the chronically disabled will be diminished due to the loss of the patient advocacy that occupational therapists have historically maintained for them. Thus, in service, education, and research the needs of chronically disabled people will not be represented by occupational therapy. The health care system, in the ensuing silence, will be further relieved of pressure to allocate resources for long-term conditions. To me, this withdrawal from a patient service is a breach of the original occupational therapy social contract.

It is reasonable, of course, to ask why occupational therapy could not pack its old ethical baggage and take it along on the shift to a client service. Certainly a client service is as ethically good as a patient service. The pivotal issue here is whether the service to a client is breached by including patient purposes and obligations.

Client ethics regulate legal and economic relationships. There is reciprocity between the worth of the service and the fee-for-service. The purpose is to ensure a just service to the client or patron; the focus is on patronage. For a client service to work financially, the person who receives occupational therapy services must be embedded in a client system.

For example, legal clients are embedded in the justice system,
and clients in social work are embedded in the welfare system. The justice and welfare systems provide the support that ensures the economic survival of lawyers and social workers. The justice and the welfare systems also provide the patronage for service. To date occupational therapy clients have no patrons. Existing patronage systems will resist sharing fees with an occupational therapy client for whom the relationship between service and fee remains unclear.

Searching for patronage and constructing a new support system is a dangerous venture for any discipline. What purposes could occupational therapy include or prohibit in a client-based service that might both attract patronage and strengthen the credibility between service and fee?

The Legal Issue
A therapist cannot treat a client; the relationship is illegitimate. Consequently, the term therapist will also have to be changed to accommodate the client role structure. The real problem, however, lies beneath any surface need for another name change. The problem concerns the rules, the glue that keeps a civilization coherent. Members of a science or profession are assumed to have a cultural sensitivity relative to the grammar of civilization. Reciprocal bonding between mother and child, husband and wife, teacher and student, physician and patient, and lawyer and client weaves the seamless fabric of culture in their lawful transactions. Occupational therapy, by proposing a therapist-client role structure, permits us to glimpse an unacceptable, indeed a rather barbaric, world. What kind of a society would it be if mother-client, husband-client, priest-client, or teacher-client bondings were permissible?

For example, American physicians have long aspired to be scientists. Yet they did not go as far as to inflict physician-subject terminology on their literature. Social work's ambition to treat led them to call one of their specialties "Clinical Social Work." They were not so foolish to risk dropping the term client and thus to endanger the financial support of the social welfare system. It confounds me to see occupational therapy propose an illegitimate therapist-client cultural bonding, and do so without regard for the social constraints this policy violates.

The Political and Economic Issues
Public policy in the United States is derived from the concern for human freedom that is spelled out in the Constitution. A democratic society views illness as a constraint upon freedom. In treating illness, which includes nurturing, restorative, and prevention obligations, society has assumed there is an equal distribution of resources to medicine, nursing, rehabilitation, and public health. In reality, however, physicians, through the positions of power they hold in national and local health institutions, have preempted the bulk of the resources.

Short-term drug and surgical treatment have excluded long-term restorative care. Massive and expensive intervention in the last few weeks of life for dying patients is seen by physicians as a more valuable service than a less expensive, more prolonged service for those who survive with permanent disabilities. Such unilateral policies of the AMA and their subspecialty groups reveal the self-interest of physicians. Financial support has faithfully followed policy shifts and transformed health care into a system hostile to the traditional occupational therapy purposes.

Under such conditions of threat, the smaller and less powerful service of occupational therapy experienced a failure of nerve. The shift to a client system represents, perhaps, a desperate strategy to survive under the awesome pressure of the self-interest of medicine. If this is so, occupational therapists need to realize the following:

1. The policy changes in the health care system that threaten services to patients with long-term chronic conditions were unilaterally made by physicians.
2. The policy change shifting from a patient to a client service was unilaterally made by occupational therapists.
3. Two wrong policy decisions seldom work in the interest of public good.
4. Public policy still reserves a niche in a concern for the restoration of daily living competency in a long-term care system.
5. The times do not require a name change as much as they require a systems change.

The American corporate world has a wonderfully appropriate metaphor describing survival during the loyalty shifts forced upon executives during mergers. Corporate executives who abandon old loyalties as they jump at new and better opportunities are said to bail out in the golden parachute.

For occupational therapy, it is doubtful that the golden parachute of a name change will work. The bad news is that there is no golden parachute ready, or easily available, for a bailout; the good and bad news is that the golden parachute has to be built; and the good news is that the historical occupational therapy experience contains the wit, wisdom, and technology to construct a golden parachute that would bail out the service out of hospitals and into the community. A community golden parachute is both a political and economic possibility, provided the ethical mistake of abandoning patient service implied in the occupational therapy name is not made.