Independence as a Practice Issue in Occupational Therapy: The Safety Clause

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This article reports findings from interviews that explored the meanings occupational therapists attach to independence as a value and a therapeutic goal in interactions with elderly clients. Through a historical review of the literature, we trace the changing use of this term and identify two analytically distinct concepts associated with it: independence as self-reliance in activity and independence as autonomy, self-determination, or choice. We show how the latter has emerged in contemporary service contexts to represent an ideal of client-centered practice for persons with chronic disabilities, such as frail elderly clients. Using a “critical incident” interview approach with 12 Australian occupational therapists, we identified the therapists’ explicit and implicit understandings of independence as a value concept and practice issue. Our findings suggest that a mismatch often exists between idealized and practice-based talk about independence and that therapists narrativize this opposition around what we call “the safety clause.” That is, therapists invoke concerns about safety and duty of care as a caveat to implementing their independence ideals and justifying the retention of professional control. We identify key issues that therapists need to address if the rhetoric of independence-related client-centered practice is to be achieved in reality.


In the occupational therapy literature, independence has long been a central concept. Independence as a value was implied in early descriptions of the profession (Baum & Christiansen, 1997; Whybrow, 1998) and had become explicit as a core value and goal of interactions with clients by 1981 (Baum & Christiansen, 1997; Beck & Ellis, 1982; Clark et al., 1997; Frieden & Cole, 1985; Holm, Rogers, & James, 1998; Rogers, 1982; Turner, 1987; Whybrow, 1998). Today, assessment scales commonly used to inform therapy planning and evaluation, such as the Functional Independence Measure (Granger, 1984; Granger, Hamilton, & Sherwin, 1986) and the Barthel Index (Wade, 1992; Wade & Collin, 1988), are directly concerned with describing a client’s degree of independence in performing activities of daily living (Christiansen, 1994; Rogers & Holm, 1998; Weingarden & Martin, 1989).

Such an orientation can be traced to the profession’s post–World War I development as an adjunct to the medical treatment of disease and injury, initially of wounded service personnel for whom activities were prescribed to aid recovery (e.g., Bell & Anderson, 1988). In keeping with the prevailing biomedical focus on curing acute conditions, the goal was the restoration of physical function to the fullest extent possible, or a “return to ability,” and, whenever possible, a return to work (Bell & Anderson, 1988; Townsend, 1998). Along with other rehabilitation disciplines, occupational therapy emphasized maximizing functional capacity, minimizing use of supports, and encouraging individual effort and perseverance in doing so (DeJong, 1979).
Throughout the 19th and much of the early 20th centuries, scientific medicine was largely disinterested in the treatment of “incurable” conditions (Russell & Schofield, 1986). However, the increasing incidence and frequency of chronic illnesses and growth in numbers of persons with long-term disabilities, partly attributable to the aging of populations, have led to demands for a reorientation of the health care system to better match the needs of persons for whom complete restoration of function is not an appropriate goal. Rehabilitation disciplines, including occupational therapy, have come to identify the need for a different philosophy and set of practices when dealing with such clients.

With this reorientation, new ways of conceptualizing independence and the goals of occupational therapy in relation to it have emerged. The concepts of “independent living” (e.g., Baum, 1980; DeJong, 1979) and “functional independence” (e.g., Christiansen & Baum, 1991, 1997; Fisher, 1992; Rogers, 1982) represent these new ways of thinking. Despite differences in emphasis, both privilege a definition of independence in which the focus has moved from physical self-reliance to client self-determination or autonomy, a movement most certainly influenced by the disability rights movements in many western societies. Both identify the client’s right to make decisions as the guiding principle for professional practice and shift the framework for working with disability from a focus on individual deficits to one that emphasizes the interaction between persons and their environment. Within this framework, persons who can make choices and direct their care, even if they cannot do everything for themselves, can still be defined as independent. Furthermore, facilitating or empowering the client’s capacity for self-determination becomes the main intervention goal. Such an orientation has significant implications for client groups that have been particularly vulnerable to disempowerment within traditional health care delivery systems.

One such group is frail elderly persons. Older people, who are the most frequent and intensive users of health care, have multiple and serious chronic disorders and face particular difficulties in exercising their rights as health care consumers (Higgs, 1997). Research has shown that relationships between health professionals and elderly clients are characterized by an imbalance of power, with the balance of power resting ultimately with the health professional (e.g., Caldock, 1994; Estes, 1993; Hasselkus, 1997; Minichielo, Russell, & Swerissen, 1992; Russell & Schofield, 1999). This imbalance exists despite a strong consumer movement that has sought to challenge the traditional dominance of health professionals. As a recent Australian review (Russell & Kendig, 1999; see also Caldock, 1994) makes clear, there is a sizable gap between rhetoric and reality in the incorporation of a consumer viewpoint into the policy-making process around care for elderly persons.

At the same time, a tremendous shift in the policy objectives of governments in Australia and elsewhere has occurred over recent decades in relation to providing health care and other services to persons with chronic disabilities, including elderly persons. The goal is to maximize the extent to which seniors with disabilities can continue “living independently” at home, thereby achieving both cost savings for government and outcomes desired by older people themselves (Caldock, 1994; Daatland, 1997; Dalley, 1996; Fine & Thomson, 1996; Giles, 1993; Lingsom, 1996). This goal is to be achieved by stemming the flow of nursing home admissions, expanding community-based services, and improving the evaluation and coordination process between institutional and home care.

Historically, medical practitioners were the key decision-makers or “gatekeepers” in the process of determining what type of service was appropriate for an elderly client’s needs. Today, this function is performed by multidisciplinary teams made up of practitioners from a number of backgrounds, including medicine, nursing, physiotherapy, occupational therapy, and social work (Opie, 1997; Russell & Schofield, 1999). Such teams are charged with identifying an older client’s needs and how these needs can be met in effective and acceptable ways. From an older person’s perspective, the most important outcome of this professional intervention is whether he or she is deemed sufficiently independent to remain at home (Russell, 1995). Little research evidence, however, shows how occupational therapists in practice understand and apply the concept of independence in their interactions with frail elderly clients.

Independence and the Frail Elderly Project

Data of relevance to this important topic have been collected as part of a collaborative project combining two complementary bodies of Australian research. The Intercultural Interaction Project (Fitzgerald, Beltran, Pennock, Williamson, & Mullavey-O’Byrne, 1997; Fitzgerald, Mullavey-O’Byrne, & Clemson, 1997) builds on more than 1 decade of multiple-methodology research that has explored various aspects of the relationship among clients and their families, service providers, and situations or contexts in which interaction between them takes place. Over the same period, the first author’s research has focused on such issues in relation to elderly people (e.g., Russell, 1995, 1999; Russell & Schofield, 1999). In all these studies, the concept of independence either was an explicit topic of inquiry or emerged as a central theme in the data.
An overall aim of the Independence and the Frail Elderly Project is to develop theoretical and empirical insights into the therapeutic decision-making process by focusing on how members of one profession—occupational therapy—define independence in relation to identifying the needs of elderly clients. We were particularly interested in whether occupational therapists primarily thought of independence in relation to task performance or privileged the autonomy model. Since the early 1980s, occupational therapists have advocated client-centered practice (e.g., Canadian Association of Occupational Therapists, 1991, 1997; Law, 1998; Mead & Bower, 2000). According to Townsend (1998), “Client-centred practice in occupational therapy is meant to enable participation so that people can realize their self-defined goals for a meaningful life” (p. 37).

What independence (or any other concept) means is not fixed or static but subject to situational and cultural definition. In other words, independence is identified within the relational setting between practitioner and client. Accordingly, we decided to investigate the perceptions of occupational therapists employed in two different organizational settings—public hospitals and community-based services. As we have seen, the profession of occupational therapy is informed by a global set of values, goals, and discourse around the concept of independence. Overall, the project sought to examine how occupational therapists construct independence as a goal of their professional practice with older people and to explore how professional ideologies might interact with organizational settings to generate different understandings, intervention strategies, or both.

Method
Design

The aim of this study was to obtain occupational therapists’ accounts of their everyday practice in relation to independence among their elderly clients. Given the qualitative, exploratory nature of the study, we adopted a purposive approach to identifying participants. We wanted informants who would be able to generate a rich body of talk about the phenomenon out of their own experience and from different work settings—data that would allow a wide range of potentially relevant themes and issues to emerge.

The Therapists

The occupational therapists involved in this project were recruited through established contacts. The Intercultural Interaction Project team has established these contacts over a period of 9 years. The project has ethical approval from The University of Sydney and other organizations to approach occupational therapists through these contacts for the purpose of research into clinical interactions in health care. All therapists gave written informed consent to participate in an individual interview.

All but 1 of the 12 therapists were women, reflecting the overall gender distribution within the profession in this community (OT Australia, 2000). Although all have worked in hospital contexts, at the time of interview, 6 were working in acute or rehabilitation hospitals providing inpatient services, and 6 were providing services to community-dwelling clients (although in some cases the service is physically based in a hospital). Most were not employed to work specifically with older clients. Those in hospital settings generally worked within another specialty (e.g., on the cardiac ward), whereas the community-oriented therapists delivered services to persons with disabilities of all ages. However, all the therapists stated that at least half and typically the majority of their clients were 65 years of age or older.

The work therapists described varied but predominantly entailed evaluation for and prescription of adaptive devices; environmental modifications; or referral to other services that provide assistance with activities of daily living, such as domiciliary home care. No specific mention was made of therapy sessions, although some therapists indicated that they provided training in adaptive methods of performance and use of devices.

The Interviews

The interviews followed the modified “critical incident” (Brislin, Cushner, Cherrie, & Yong, 1986; Brislin & Yoshida, 1994; see also Arthur, 2001; Edwards, 1999; Hasselkus & Dickie, 1994; Sue & Sue, 1990), ethnographic interview (Spradley, 1979) approach developed for the Intercultural Interaction Project (e.g., Fitzgerald, 2000; Fitzgerald, Beltran, et al., 1997; Fitzgerald, Mullavey-O’Byrne, et al., 1997). The interviews had three main foci: 1. An account of the therapist’s overall work context and role 2. A request for the therapist to define independence in relation to elderly clients 3. An invitation to talk about practice-based situations in which the therapist thought independence had been an issue; in other words, therapists were asked to tell one or more stories, or critical incidents, with independence as a primary theme

Therapists then were encouraged to discuss the situations and offer their interpretations of the events. The ther-

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According to the OT Australia–NSW 1999–2000 Annual Report, 96% of the occupational therapists in New South Wales, Australia, are women.
apists’ definitions of independence and these “independence stories” provided a focus for directly and indirectly exploring therapists’ understandings of the concept of independence and the range of practice issues they associate with it.

Briefly, critical incidents refer to distinct occurrences or events which involve two or more people; they are neither inherently negative nor positive, they are merely distinct occurrences or events which require some attention, action or explanation; they are situations for which there is a need to attach meaning. (Fitzgerald, 2000, p. 190; see also Fitzgerald, Mullavey-O’Byrne, et al., 1997)

As Fitzgerald (2000) noted, the critical incident approach is based on the idea that people use narratives or stories to communicate, problem solve, understand, relieve, and even shape and give meaning to personal experiences. Storytelling, a basic form of communication, is consistent with the way therapists (and others) interact with colleagues to address issues in practice. As in previous research, we found that therapists were comfortable with this “talk story” (Fitzgerald 1989; Fitzgerald, Paterson, & Azzopardi, 1997) style of interviewing and narrative reasoning (see also Hasselkus & Dickie, 1990, 1994; Mattingly, 1998a, 1998b; Mattingly & Fleming, 1994).

All of the interviews were conducted by a qualified occupational therapist (the third author) who had previous experience in this type of research. Interviews ranged in duration from 1 to 2 hr, with an average of 1.5 hr. All were tape recorded with the therapist’s permission and transcribed in full.

The Analysis

Several analytical techniques were used. First, each transcript was subjected to a process of open coding around each of the a priori categories of interest (e.g., therapists’ explicit definitions of independence, descriptions of their organizations and work roles, identification of profession-specific values). Second, each story was summarized as a flow chart of the interaction as told, highlighting the following key points: the therapist’s expressed aims; description of the client and interpretation of his or her needs; the activities that took place during the interaction; the intervention(s) that the therapist recommended, that were actually implemented, or both; and the therapist’s evaluation of the outcome. These stories were inspected for patterns and themes.

The incidents then were written up as coherent stories by one or more persons and reviewed or compared. In this process, the goal, as Fitzgerald (2000) noted, is to maintain the integrity and complexity of the story while removing some of the normal digressions common to everyday discourse—digressions that can make such stories difficult to follow by persons unfamiliar with the transcripts. This step is, by its very nature, interpretive.

Throughout this period, project members met regularly to review these analyses and ensure consistency in the analytical procedures. In those meetings, they also engaged in the kind of “free-floating” analytical, interpretive process of the kind described in detail in Fitzgerald, Beltran, et al. (1997), where they let the data “reverberate” in their minds “against extant knowledge and information in order to come to some analysis, interpretation, or conclusion” (p. 105). Then two (and often more) team members went back to the data to confirm that the idea or interpretation truly represented the data.

Following the principles of the constant comparative method (e.g., Glaser & Strauss, 1967; Strauss & Corbin, 1990), these analyses proceeded simultaneously with data collection, and emergent categories were “checked out” in later interviews. For example, each of the first three interviews generated considerable talk about “safety,” both as a spontaneously introduced category of talk in relation to therapists’ definitions of independence and as a dominant element in their storylines about independence as an issue. In subsequent interviews, the interviewer probed more deeply around this concept when it was introduced by the therapist, as it invariably was. All the therapists stated or implied that a central issue for them was the potential conflict between the client’s right to do what he or she wanted and what they saw as their professional responsibility to keep the client safe.

Findings

This article reports on a subset of the data, focusing on what the interviews revealed directly (explicitly) and indirectly (implicitly) about therapists’ understandings of independence as a practice issue. Other findings, notably in relation to the influence of different organizational settings on therapists’ understandings, will be discussed elsewhere. In the present context, however, it is important to note that no clearly identifiable differences were found in the way that independence was defined or narrativized by hospital-based and community-based therapists.

We begin with an account of how the therapists talked explicitly about independence. All therapists provided a definition of independence when asked to do so, and all were able to give an example of an interaction with an elderly client in which the main issue was independence. Many remarked that they could give more than one example. According to Cathy (all names are pseudonyms), for
instance, “That's really all of the clients—I mean, their issue is being independent.”

**Therapists' Definitions of Independence**

In response to a direct question about what independence means, all therapists directly or indirectly addressed the distinction (also found in the professional literature) between self-reliance and autonomy. However, they did not use a common language to do so. A few used the term independence to refer exclusively to self-reliance, some to refer exclusively to autonomy, and others to some combination of the two. Leanne, for instance, talked about the difference as a contrast between “physical independence” on the one hand and “independent thinking” or “free will” on the other:

I thought...independence was independent thinking really, and that was the way that I saw it because she was thinking on her own and of her own free will, and that was a really big indicator for me that independence doesn't just mean physical independence. Independence means the ability to think on your own and stand up for your own rights.

Hermione made the same point through a distinction between “doing everything themselves” and being “in charge”:

From my point of view, they don't have to be doing everything themselves to be independent, they just have to be able to manage their own life and be in charge of their own environment, which includes other people coming...at their request.

Some therapists elaborated on this theme by giving independence an environmental dimension. Thus, Leanne added that an important aspect of independence was “being in the environment you choose.” All therapists who talked about an environmental dimension of independence invariably linked it with being at home. Several, like Brenda in the following extract, specifically associated being in an environment other than home with the absence of choice and, therefore, of independence:

The worst scenario is they break their hip. Well, then they won’t be independent, will they? Usually a lot of them end up in a nursing home. So that's what we're trying to do, prevent that happening....They don't have good thoughts about going to nursing homes. I'd say they want to stay in their own homes, be independent.

For some therapists, simply being at home—in the environment of one's choice—was the crucial defining feature of independence, regardless of how much the person relies on others for assistance with daily activities. According to Gwynnnyth, independence meant “being at home even if the client was getting a lot of help.” Others, however, did not define such a situation as being independent. To Kelly, the goal of her practice was to maintain clients at home, but they would not necessarily be “independent” if they needed “support” to do so:

I try to organize their home environment with them and work towards maintaining their optimal level of function in the home, either independently or with the support of carers and services and using equipment [italics added].

Several therapists talked explicitly about independence as a kind of continuum or hierarchy, with an “ideal” at one end consisting of both self-reliance and autonomy. Leanne put it this way: “What I would ideally see as the ultimate independence is that people can do everything for themselves in their chosen environment.” All therapists in one way or another drew attention to the distinction between what we are referring to as autonomy and self-reliance, making clear that they placed higher value on the former.

As noted, Leanne linked her definition with the idea of clients’ rights. Brenda and Isabelle also saw facilitating client choice as central to their therapeutic role:

I think it comes down to choice. Independence is that you've got your own choice, and they [her clients who are socioeconomically disadvantaged] don't have their own choice. So most of the people that I see, I see because they don't have any choice, and I'm trying to create the choice. (Brenda)

So it's a matter of taking what's important to the actual client themselves and then looking at that aspect as to what you can reach in terms of independence. (Isabelle)

In other words, among these 12 therapists were different perspectives on what independence “really” meant. Some believed that a client who cannot do everything for himself or herself can still be defined as independent as long as the client feels “in charge” or “in control” of the situation. Others say that a person who relies on others for assistance with daily activities is not really or completely independent.

At the same time, however, when the therapists’ talk shifted from offering a conceptual definition of independence to a discussion of its significance as an issue in their own professional practice, every one of them maintained that what ultimately directed their therapeutic interventions was “what the client wanted.” Thus, the therapeutic role was described in terms of facilitating client choice.

The following extract from Isabelle’s interview aptly summarizes how “as an OT” she thinks of independence in relation to how much clients can “do for themselves.” At the same time, however, she makes clear that she sees herself as working to achieve “what's important to the actual client themselves,” that is, adopting client-centered practice:

I suppose as an OT you'd be looking at the whole lifestyle and quality of life. So in terms of independence, it would be in their basic daily living, their self-care...[and] instrumental activities of daily living...It's a matter of taking

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2Many quotes have been edited slightly to add clarity.
what’s important to the actual client themselves and then looking at that aspect as to what you can reach in terms of independence.

However, when therapists grounded their talk through storytelling about an interaction in which independence had been an “issue,” their stories were examples in which a mismatch had occurred between the ideal and the real. In stark contrast to the abstract valorizing of the centrality of client choice and self-determination, many of their stories described situations in which they had ignored it. Here we focus on one of many sets of stories in this database that exemplify this point—those that revolve around the concept of “safety.”

**Therapists’ Stories About Independence as an Issue**

When asked to narrativize independence as a practice issue, the therapists told us stories that revolved around themes of opposition and struggle. As Nouri and Helterline (1998) explained, when people tell such stories, we develop the “character” of our selves as well as the “characters” of others and descriptions of events in which the “characters” develop. These oppositions can be thought of as the “troubles” or “plight” that provide the plot and are essential to being able to tell a story at all…Each type of story line has its own form of opposition. (p. 54)

Critical incidents, as stories or “social dramas,” often can be viewed as “units of harmonic or disharmonic processes” (Turner, 1974, p. 37). Critical incidents often represent a conflict of cultures, values, standards, and goals (Sue & Sue, 1990), but, as Fitzgerald (2000) pointed out, critical incidents do not necessarily arise out of situations that are explicitly conflictual. Often, the conflict arises out of “disconfirmed expectancies” (Brislin et al., 1986; Fitzgerald, Mullavey-O’Byrne, et al., 1997; Mullavey-O’Byrne, 1994): There is a mismatch between what happened and what was expected or desired.

Two therapists told stories about opposition between themselves and other health professionals over whether a particular hospitalized patient was “independent” enough to return home. Both Leanne and Danielle described situations where they acted as the client’s ally in the struggle and successfully avoided nursing home placement. Leanne recounted the case of a 98-year-old woman who had sustained a femoral fracture for whom “independence became a big issue” between herself and the hospital nursing staff. The patient was “determined” to go home, but the nurses opposed this: “They said she wasn’t able to look after herself.” Leanne conducted a home visit and organized home help three times a day with meals and personal care. As she put it:

> What the [nursing] staff saw as being independent was that you had to be able to wash yourself, dress yourself, get yourself up, get yourself moving, do all those things on your own without relying on anyone else, but for this lady, to be independent meant living in her own home.

By far, however, the most common storyline involved some form of opposition between the therapist and a client. In these stories, independence was an issue because of a mismatch between “what the client wanted” and the therapist’s definition of the situation. In all these cases, the independence issue that the therapist described revolved around the concept of safety. Leanne, for instance, described the case of an elderly hospital patient who

…wanted to go home and live at home, and to her, being independent was…just getting home and not having anyone help her….So there was an issue in that I didn’t particularly think that she should go home; I didn’t feel that she was safe; I didn’t feel that she would manage at home….Yet, she was able to identify that she wanted to go home, so that was a difficult situation for me.

**The Safety Clause**

Leanne was quoted earlier as defining her “ideal” or “ultimate independence” as the situation in which “people can do everything for themselves in their chosen environment.” Yet here, the patient’s choice of environment produced a “difficult situation” because in Leanne’s view, the patient might not be “safe” there. As Leanne went on to explain, the “ultimate independence” was simply not possible for many people, and in practice, it was often desirable for independence to be “overridden” in the interests of safety:

> So basically what I look at is: Are they safe doing these basic tasks, or do they need someone to help them to be safe? I don’t have time to get them to be as independent as possible….So overriding the independence issue is the safety issue, I think.

Similarly for Kelly, independence emerged as an “issue” when a client’s preferences entailed what she assessed as a safety risk:

> She was quite determined to prove to me that she could manage by herself, though she was unsafe at times during the activity [showering]….She nearly burned herself….Yet, she refused to allow me to intervene. She was determined that she would do it by herself, so she wanted to be independent in that task where she was unsafe.

Underlying Kelly and Leanne’s concern was the potential conflict between the client’s legal right to do what he or she wanted and their own professional responsibility or duty of care, including possible repercussions for themselves if a client sustained an injury. Many other independence stories involved situations in which the therapists had doubts about the client’s cognitive capacity to make safe choices. In such cases, the relationship between rights and responsibilities was blurred (e.g., see the works by Hassellkus and col-
leagues, especially Hasselkus, 1997). Kelly summed up this dilemma and how she dealt with it:

It's not up to me to determine whether a patient has insight or not. I can give them choices, and I can make my own assessments from their responses...as to their cognitive ability. But if that person's in their own home, and they don't have a guardianship order or anything like that, and they don't have carers or family members who are happy to make decisions and take responsibility for them or who they're happy to give that responsibility to, then you have to give them the benefit of the doubt and allow them to take those risks and make those choices, even though they may be putting themselves at risk. You just have to document it clearly.

Therapists’ storylines about this kind of mismatch included accounts of the strategies they used to try and overcome it. Essentially, these accounts revolved around attempts to persuade the client to the therapist’s way of thinking.3 Mark described how he would “subtly” approach a client who did not see things his way:

I will stress that in my opinion it would be a good idea, but I never force them to do it. It’s really their choice, it’s their life, and if they don’t want something to happen, if you bring around a piece of equipment to make it easier, they’re not going to use it, they don’t want to use it. Normally, you wouldn’t coerce a person, but you might subtly say, “Well, it’s free, it’s a trial run, why don’t we see how it goes.” That works brilliantly.

Similarly, Edwina recounted how she managed to persuade a reluctant hospital patient to accept her point of view that he was not able to go home because he would not be safe: “We did a home visit and looked at some really clear-cut examples to give to him.”

What we see in these stories is an evoking by therapists of what we call a “safety clause,” not only out of concern for the client’s welfare and the professional well-being of the therapist, but also as a caveat to idealized definitions of independence. The caveat is that people can be allowed to be independent (autonomous decision-makers) as long as they are safe to do so—in the opinion of the therapist. In such situations, then, the same imbalance of power exists as is noted in other studies of service delivery to elderly persons but with what is clearly viewed as a valid and reasonable caveat that attempts to explain why this imbalance is justified.

Interestingly, although several of the therapists referred, in general terms, to the existence of financial constraints on the health care system that adversely affected client outcomes, none told a story in which constraints had been an “issue” for them. Anne was one of several therapists who described “a fairly major intervention” involving considerable cost, including extensive home modification, to enable an 82-year-old woman to access her bathroom as well as to provide “6 hours a week of a carer who can take her out so she can get her bills paid and do some shopping and also take on some leisure outings to nurseries and things like that.”

Anne identified this resolution as successful. When asked for an example that was not such a success, she told the story of Michael, a 68-year-old man who had recently separated from his wife and moved to his own department of housing unit. Anne initially was referred to see about putting some grab bars in his bathroom. She went into considerable detail about Michael’s multiple health problems: He was a heavy smoker and, previously, a heavy drinker; a stroke had left him with hemiplegia and no left upper-limb function; he had undergone cataract surgery (successfully); he was “deaf as a post,” had gum disease, and was incontinent of urine; and hydrocephalus had been discovered after he had a seizure earlier in the year. As Anne put it, “He’s a bit of a wreck, basically.”

She described how Michael had told her that what he really wanted was a power wheelchair: “He wants [it] for his reasons for doing, that is so that he can get out and about,” but Anne did not prescribe him one: “I really don’t feel I can justify using government money to prescribe him a power wheelchair. It’s very frustrating for him, but the things against it are safety issues.” Instead, she organized home visits for personal care and arranged that once every 2 weeks “one of the male HomeCare staff will take him out to the local club” in a taxi for which Michael pays. In all, these services cost him $70 to $80 a month, “and he’s not very happy about that.” Anne summed up the outcome of her intervention in this way: “He would still feel that having the power wheelchair would be the answer to his independence.” To the interviewer’s follow-up question about whether Anne sees Michael as being independent, Anne replied:

I’d see him as not being independent because he’s not able to do what he wants to and what he would like to. I feel uncomfortable with that, with not being able to [pause] give him the freedom of access to community life that he would like to have.

In other words, Anne did not privilege this client’s own choice or enable his independence as she understood it, despite both her own misgivings and the fact that it had been within her power to do so. (Remember, the “successful” outcome she had previously described had been achieved at considerable expenditure of “government money”—a “level of support” Anne evaluated in that case.

For similar accounts in relation to different perceptions in terms of mental illness, see Fitzgerald, Beltran, et al. (1997).
as “reasonable.”) In explaining her decision about Michael, Anne invoked the safety clause: “The things against it are safety issues.” She went on to specify that these were multiple, including the “issue about his visual safety,” the fact that he lived on a busy road so that “his hearing is a major safety factor,” and that there is a “grade one-in-eight ramp at the front of the property which I don’t think is safe.”

But even Anne is not ultimately convinced by her own argument that this is a clear-cut example of a professionally legitimate invoking of the safety clause. She added that “the home environment is totally unsuitable for an electric wheelchair” (although she noted that “probably one of the new mid-wheel drive chairs would just do it”); in any case, she has told us that Michael wanted the chair to go out, not to negotiate his apartment. The other theme in Anne’s justification for not facilitating client choice is—in the ultimate paradox—that he wants a power wheelchair “for his reasons.” “This man really wants a power wheelchair, which I just don’t, he wants a power wheelchair for his reasons…so that he can get out and about.” Clearly, the “issue” that Anne is reluctant to articulate (“which I just don’t”) is that she does not approve of “his reasons” or, more aptly, her interpretation of them: “I suspect he wants the chair so he can get down to the club and drink, and he’s not supposed to be drinking.”

The details of this practice situation are in stark contrast to her narrative valorizing of the centrality of independence—client choice and self-determination—to her practice with the first client, an elderly woman whose motivations Anne approved of (basic self-care, shopping, recreational outings to “nurseries”). In Michael’s story, Anne described a situation in which she ignored the client’s expressed wishes. Finding out what the client wants was not, in this case, enough, even though she accepted it in principle as a valid want—Anne herself pointed out that the stairs in Michael’s previous unit had been an obstacle to his ability to socialize. Rather, Anne overlaid the client’s evaluation of his needs with her own. She was only prepared to offer him limited “freedom” to do what he wants—a beer at the club once every 2 weeks, under supervision. In doing so, she defined the situation as a “duty of care” issue in which “safety” considerations take precedence.

Discussion

Overall, our findings indicate several things about the concept of independence in relation to occupational therapy practice with frail elderly persons. First, the word independence itself is used to mean different things. Among these 12 therapists, no common “textbook-like” definition was given: some used independence as a synonym for physical self-reliance, some as a synonym for self-determination or autonomy, and some to encompass both as part of a continuum of kinds or degrees of independence. However, when they talked about independence in the context of their professional practice (rather than as an abstract concept), it was clear that they shared a common set of values in relation to the “proper” goal of occupational therapy; namely, that interventions should be focused around “what the client wants.” In other words, these occupational therapists appear to have embraced the new empowerment models of practice, such as independent living and functional independence.

But we have seen that the rhetoric is not always matched in the stories told about practice, that there is a breach between the “real” and the “ideal” (Whybrow, 1998). Moreover, it is precisely where a mismatch exists between the client’s preferred response and the professional’s definition of the situation that independence is most likely to become a practice issue. These situations are similar in many ways to some of the ethical dilemmas described by Hasselkus (1997) involving persons with dementia who are in adult day-care environments where health professionals make decisions or take control of decision making by “recontextualizing the ideals of ethics” (p. 648) in light of their evaluation of the clients’ capabilities.

What these data from the Independence and the Frail Elderly Project further disclose is that for occupational therapists, there is a particular way of explaining and justifying occasions when their actions did not privilege the client’s viewpoint and preferences. We have called this the “safety clause.” The safety clause is invoked when an opposition or breach occurs between what clients want and what the therapist believes is in the client’s best interests to explain and justify why the balance of power should remain in professional hands.

In their narrativizing of independence as an issue, this form of opposition was not the only one expressed, but it was clearly the most problematic for the therapists themselves. Other forms of opposition—from other health professionals or from the physical environment—also entailed struggles. Presumably, not all of these other struggles are actually resolved in the therapists’ favor, but in these interviews, only those that had successful outcomes for therapists were recounted.

By contrast, their stories about struggles between therapist and client had different endings and variable evaluations. Some mismatches led to unsuccessful outcomes from the therapists’ perspective. This was clearly the case in stories about clients who, despite professional opposition, did in fact exercise their right to refuse help. Indeed, for the
therapists who told such stories, independence was an issue precisely because they had been unable to impose their own values and preferences in determining the outcome. In other cases, therapists described a successful outcome of their struggle with an initially recalcitrant client. Here they talked about how they had managed to overcome the client’s opposition by persuading him or her to accept the “correctness” of the professional’s viewpoint.

Implications for Occupational Therapy

The nature of the work of occupational therapists in hospital and community settings means that therapists regularly provide service to significant numbers of frail elderly persons. Within the multidisciplinary teams that have come to characterize aged care evaluation and resource allocation, they have particular responsibility for evaluating the capability of an older person to live at home and in making recommendations that will facilitate (or not) such an outcome. The perceived ability of an older person to be independent, or to respond to the demands of a particular environment, is a significant part of the clinical evaluation. From the older client’s perspective, the outcome of such evaluations can be of life-maintaining, or life-changing, dimensions.

Our work suggests that the disjunction between theory and practice can be a source of frustration and concern to therapists themselves. While valorizing the centrality of clients’ own “self-defined goals for a meaningful life” to professional decision making, occupational therapists find that it is not always possible to implement such a model in practice. They described experiencing situations that are aptly characterized by the metaphor of being “between a rock and a hard place.” The pivotal issue they identified here is what we have called the safety clause.

Clearly, there can be no simple solution here, but we suggest that an important beginning can be made if the profession as a whole engages in some critical reflection on how it defines and uses a core concept like independence. As we have shown, the term independence itself is ambiguous, and therapists lack a common vocabulary with which to frame relevant questions, let alone consider the implications of different answers. A necessary first step is to disentangle self-reliance from self-determination both as empirical phenomena and as practice goals. Each has different implications for older persons themselves and for those who are responsible for providing therapeutic or supportive interventions in their lives.

At the very least, professional education and research oriented toward best practice will benefit from greater precision in identifying what occupational therapists actually do, what they aspire to do, and how they can transform valued theory into practice. Our findings suggest that further inquiry will benefit from specific attention to the role of the safety clause in the everyday discourse of occupational therapists.

Such inquiry, we suggest, should not be limited to exploring the internal ethical struggles with which individual therapists deal. Social scientists have emphasized that individual action cannot be fully understood without reference to the wider “structures of practice” (Connell, 1995) within which it takes place. As other research into the delivery of aged care and mental health services (e.g., Russell & Schofield, 1999; Townsend, 1998) has shown, existing structures of practice often do not support, and sometimes do not even allow, the implementation of such an empowerment model. In our interviews, for example, several therapists referred directly or indirectly to the potential professional and personal consequences for themselves if a client’s choice proved to be “unsafe.” From this perspective, the retention of professional control could be interpreted as an inherently systemic problem rather than simply a matter of an individual therapist’s personal values.

Finally, we would emphasize that the profession of occupational therapy is particularly well placed to take the lead in articulating and developing responses to the “independence issue.” Perhaps even more so than for other rehabilitation professions, independence historically has been identified as a core value and practice goal of occupational therapy. Occupational therapists can, and we believe should, stake a claim as key players in working out what a genuinely client-centered practice would look like. ▲

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