The Patient-Therapist Relationship: Beliefs That Shape Care

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The results of a previous inquiry suggest that three images of occupational therapists dominate patients' stories about them: the images of technician, parent, and collaborator or friend. These ways of being in practice can be said to reflect the various understandings that therapists have about how to enact the profession's commitment to both competence and caring. When therapists act as technicians or authoritarian parents, patients register their disappointment over a valuation of competence that excludes caring actions. In a more current inquiry into the climate of caring, patients and caregivers reflect about the current health care system and identify three societal constructs that shape a preference for competence over caring: (a) emphasis on the rational fixing of the health care problem, (b) overreliance on methods and protocols, and (c) a health care system driven by business, efficiency, and profit. Occupational therapists who are concerned about complaints that the health care system is increasing uncaring might benefit from a consideration of the extent to which societal beliefs shape the manner in which they care.

Nature and Scope of the Inquiry

This article constitutes part of a larger inquiry into the challenge of creating a climate of caring. Conducted between January 1990 and September 1991, the inquiry considered the following: (a) personal narratives that describe impersonal treatment; (b) the historical events and societal constructs that have shaped the patient-helper relationship; (c) empathy and the manner in which helpers learn to be empathic; (d) the nature, practice, and experience of art; and (f) the proposition that empathy might be cultivated through the use of art. Each step of the inquiry required an extensive literature review from which important themes emerged. These themes were...
Pekkanen willed himself to feel the boy’s injury from the inside out. He then understood:

The Connections That Mean Care

A number of phenomenological narratives about the impersonal treatment of patients served as subjects for an earlier discussion (Pelouquin, 1993). That discussion produced a descriptive profile of those behaviors to which patients refer when they use the term depersonalizing. The central complaint found within those narratives was that when practitioners act impersonally their behaviors are discouraging. Patients say that helpers fail to see illness and disability as emotional events charged with personal meaning. They fail to attend to the experiences of patients; instead, they establish a distance that diminishes them. They withhold information, they use brusque manners, and they misuse their powers. They are insensitive, silent, and aloof. Patients conclude that their helpers may treat them, but they do not treat them well.

Alongside these descriptive narratives were a number not included in the discussion on depersonalization because they were more reflective than descriptive: (a) those written by patients who consider the beliefs that may cause their helpers to behave carelessly; (b) those written by caregivers who, after their own bout with illness and impersonal treatment, discuss societal expectations; and (c) those written by helpers who ponder the difficulties of caring. These reflections offer cues about the societal constructs that may have a hand in shaping care, and, as cues, they constitute assumptions that can direct further research.

This discussion does not address concerns in practice such as that Bailey (1990) described as the “harmful variables” that cause therapists to leave the field (p. 23). Staff shortages, large caseloads, red tape, excessive paperwork, lack of job status, chronic conditions of the patient population, lack of respect for occupational therapy by other professionals, stress and overload, and the need to justify treatment also shape decisions about the manner in which helpers will choose to care. Many of these negative variables, although not the specific focus of this inquiry, can also be said to associate with the societal beliefs that are the subject of this discussion.

The Emphasis on Rational Fixing

One societal belief that compromises caring actions is the emphasis on solving discrete health care problems in a logical and rational manner. When Hodgins wrote in 1964 after his stroke, he found a particular form of disregard at the heart of the problem. He described this picture of the patient and the caregiver perceive illness:

A caring attitude can encourage patients. Lee (1987), a patient hospitalized with cancer, felt care in this small gesture:

As I slept a nurse took the cloth wrapping off a sterile instrument. He smoothed out the material. He painted with a blue flow pen a moon face with wide eyes and an enormous crescent smile. He climbed over my bed. He climbed over my plants and hung this banner down from my window, using the extra-wide masking tape. It was the first thing I saw in the morning. (p. 111)

Patients also draw courage from caring words. Benziger (1969) remembered the encouragement that she took from this conversation with an occupational therapist:

"You know, you go at your work too hard, too fast, too desperately—and too frenetically."

"I guess I do, but that's the way I feel. Time stands still for me now, it is endless, and yet if I have something to do, I get the sense that there will not be time enough to finish it, or that someone will stop me."

She said, "You are an intelligent person, and you will help yourself to get well quickly;" "You know, I answered, "you're the first person who has mentioned intelligence versus non-intelligence, instead of sanity. You make me feel like a human being." I was grateful. I should not forget her. (p. 49)

The directness and the professed confidence held in these words meant concern to Benziger; she would call this therapist friend.

Sarason’s (1985) point of view is no doubt the most helpful. At the very least, he said, practitioners can try. Patients, he says, mostly ask helpers to try “in ways that say I am trying to understand because I want to be helpful.” It is those manifestations that are experienced as caring and compassionate, even though they may be more or less ineffective” (p 188). And when “a patient, whether terminal or not, draws courage—courage to live or courage to die—from the man who stands at his bedside” (Hodgins, 1964, p. 843), surely they both feel the magic of care.

If practitioners can be both competent and caring among their patients, what societal beliefs cause them to act otherwise? Three constructs surface within the reflections of patients and practitioners as shaping forces that compromise caring expressions: (a) an emphasis on the rational fixing of problems; (b) an overreliance on methods and protocols; and (c) a health care provision system that is driven by business, efficiency, and profit.
In stroke two basic sets of assumptions could govern treatment. One set proceeds from what the patient perceives or thinks he perceives; the other comes from what the doctor knows or thinks he knows. The two are very different sets of things. (p. 842)

Many health care narratives hold similar pictures, with helpers governing some aspects of care while neglecting others that their patients value. Sir Dominic Corrigan, a physician, argued as long as a century ago that the trouble with doctors is "not that they don't know enough, but that they don't see enough" (cited in Taylor, 1972, p. 6).

Van Eys (1988), also a physician, has regretted the hemisected worldview in which "diseases become problems, and patients become dissected into such problems" (p. 21). Patients resent this narrowness of focus because it feels uncaring. They complain that practitioners address their disease, the physiology and the mechanism of their bodies and dysfunctions, but not the experience of illness and unease, not its meaning, and surely not their feelings.

Disregard for parts of persons disturbs Murphy (1987), an anthropologist who wrote of his own disabling illness: "The full subjective states of the patient are of little concern in the medical model of disability, which holds that the problem arises wholly from some atomic or physiological disorder and is correctable by standard modes of therapy—drugs, surgery, radiation, or whatever" (p. 88). Sacks (1983), a neurologist who experienced impersonal care, considered this splitting insane:

- All the smmach, baskets. Each parallelies in his workweek, ends, and four or six days later his bed reaches the exit and the patient is healed—we hope. (p. 138)
- If this reduction is a prevalent view, is it fair to expect practitioners to think divergently, to routinely see and treat a self embodied instead of a body? If the general population views the body as a mechanism controlled by higher functions, as something that one has instead of who one is, why the surprise that practitioners engage only their rational functions in practice? If imagining patient experiences, sensing patient needs, and expressing personal feelings seem actions incongruent with fixing, practitioners are quite reasonable in underusing these so-called lower functions. What is the problem, then, with treating bodies when they need fixing?

Most narratives answer that "when a patient appears as a physiological mechanism, the doctor may neglect personal communication in favor of the immediate scientific task at hand" (Leder, 1984, p. 36). The preference for fixing makes it easier for a helper to neglect feelings, easier to justify being silent, curt, or aloof. The resulting problem is impersonal care. Any caregiver can focus narrowly on fixing. Gelbols (1990) remembered this incident:

- A male therapist came in whistling and cheerfully setting up his equipment. He stuck the breathing tube into my mouth and told me to "breathe" which I did while he walked around the room admiring my flowers, gazing out the window and remarking what a lovely day it was. (p. 35)

Mattingly (1991) gave occupational therapists pause for reflection when she argued that "therapists can come to reduce their practice to a manipulation of the physical body, forgetting how much their interventions are directed to a person's life" (p. 986). Parham (1987) argued that there are such situations in occupational therapy when

- time, energy, and money are funneled into treating one small part of the total problem, a part that may be insignificant in comparison with complexities that are more difficult to understand but that have a profound impact on the life situation of the patient being served. (p. 596)

Schultz and Schkade (1992) shared a similar concern: "The current demand for therapists to base occupational therapy on acquisition of functional skills . . . may actually limit the contribution of occupational therapy and may deny patients the opportunity to make vital changes in their occupational adaptation process" (p. 918). Certainly a patient's poem, "Some Other Day" (McClay, 1977), presents an occupational therapist bent on partial fixing:

- Preserve me from the occupational therapist, God
She means well, but I'm too busy to make baskets . . .
- "Please, open your eyes," the therapist says:
You don't want to sleep the day away.
- She wants to know what I used to do,
A second societal belief that compromises caring is an disregard that feels careless. And although practitioners whose reliance on protocol precluded personal attention, acknowledged the problem: "Professions tend to be right in what they affirm and wrong in what they ignore" (p. 3).

**The Reliance on Method and Protocol**

A second societal belief that compromises caring is an overreliance on the instruments of health care practice: the techniques, procedures, and modalities that solve the problem. When they are ill, patients seek concern in addition to solutions. They grieve that in health care practice they find something else. Hodgins (1964) regretted the find:

For the physician, of course, it must have been wonderful, indeed, when true specifics began to arrive on the scene to supplant beef, iron, and wine or syrup of hypospheres. . . . As so-called science more and more enters medicine, the heedless or routine physician will be accordingly tempted to withdraw his humanity and wait for specifics. (p. 843)

Hodgins considered the specifics needed for cure and the humanity needed for care different but inseparable aspects of care. Flagg (1923), a physician who practiced at the turn of the century, agreed; he regretted "the unwise employment of laboratory methods to the exclusion of personal attention" (p. 5).

When a drug or a procedure suffices, a practitioner may think less about the need to make meaningful connections with the patient. The problem becomes clear in Barbara Peabody's (1986) recollection of an incident that occurred during her son's hospitalization for acquired immunodeficiency syndrome (AIDS):

Peter woke at two A.M., just as the intern was about to give him an injection in his left thigh.

"What do you have there?" Peter asked.

"What do you care?" the intern snapped back.

"I care very much, and I hope that's not pentamidine."

"What if it is?" the intern asked insolently.

"Because if it is, I'm not supposed to get it anymore." Peter replied. "I think you better check my chart and you'll see that it was discontinued on Monday."

"Oh, no, the orders are still on your chart."

"I'm sure they're not," Peter insisted. "Go back and read them again, you'll see that I'm right."

The intern left the room and never returned. (p. 51)

Reiser (1980) told the following story about helpers whose reliance on protocol precluded personal attention. A woman hospitalized with a diagnosis of acute granulocytic leukemia and severe anemia agreed to an aggressive course of chemotherapy that made her quite ill. She was discharged after remission, and when she was readmitted 4 months later she refused chemotherapy. The staff decided that if she continued to refuse this treatment, she would be discharged Against Medical Advice. She refused and was discharged. Reiser's perception was that she had "stepped out of the established 'system' and had to be punished for it" (p. 146).

Sacks (1983) rejected the argument that helpers must use only treatments or protocols. When facing surgery, he wondered,

What sort of man would Swan be? I knew he was a good surgeon, but it was not the surgeon but the person that I would stand in relation to, or, rather, the man in whom, I hoped, the surgeon and the person would be wholly fused. (p. 92)

Cassell (1985), another physician, shared a similar belief: "Doctors who lack developed personal powers are inadequately trained. . . . Doctors are themselves instruments of patient care" (p. 1).

When they are effective, however, methods and protocols take the upper hand. Helpers side with what works, so that a challenge to the procedure also threatens them. Martha Lear (1980) remembered the upshot of such an identification when her husband Hal, a urologist, requested a milder painkiller: "The resident got angry. He said, 'There is a medication ordered for pain for you. If you want it, you can have it. If not, you'll get nothing.' And he walked out" (p. 41). But patients, wrote the physician Pellegrino (1979), do not want practitioners to fuse with their skills: "Physicians have a medical education, an M.D. degree, a set of skills, knowledge, prestige, titles. They possess many things by which they mistakenly identify themselves" (p. 228).

Helpers wrap themselves in their procedural authority, binding themselves so tightly in their concern for the right method, the latest technology, that it is no wonder that their actions then seem constricted. Helpers can never be seen as personal if they offer knowledge or skills instead of themselves. Murphy (1987) restated the trade: "What I needed was not a new instrument, but an old-fashioned clinician with plenty of intuition" (p. 14). Patients argue that their helpers routinely neglect their feelings, that they have bought the argument in favor of impersonality.

But whenever anyone mentions using either selves or intuitive traits therapeutically, practitioners stir uneasily. They have a problem with being intuitive or personal. Some actually call caring feminine. Lear (1980) claimed that her husband felt care from women, distance from men: "They were with him constantly, those woman figures. They were gentle and good. . . . The male figures were with him for ten minutes a day. They were marginal figures, shadowy and cold. They touched him with instruments—stethoscopes, blood-pressure gadgets" (pp. 40–41). It seems that here too helpers try to split the
inseparable; they say that men will offer cures and skills, women service and caring. But patients argue that this and all other separations are unthinkable; all helpers must care.

Hodgins (1964) argued that encounters felt as personal are often what patients need most: “[The patient] will draw courage as he perceives human understanding underlying the professional techniques of those into whose care he has been given. Human understanding, however, is not to be found in the rituals of anything called medical science” (p. 841). Unhappily, concern for more personal issues seems to matter little in this formulaic belief. Correct procedures produce the superior results that serve the patient’s best interests.

Occupational therapists are among those who must admit that techniques and protocols can preempt caring. Yerxa (1980) argued that “technique, once employed in the service of human needs, is rapidly moving us toward a society of total technology in which our ways of thinking and being themselves become so technical that we lose sight of other ways of thinking and being” (p. 530).

King (1980) concurred, claiming that “therapists have ignored their instinct for caring” (p. 525). Heller and Vogel (1986) described Heller’s experience with the tight formula in his occupational therapy treatment for Guillain-Barré syndrome:

As soon as I could sand a block of wood (with need-to-rest both arms, it was written, after seven repetitions), a change was made to a coarser grade of sandpaper, increasing the amount of force required, and it was just as punishing for me to have to execute them as it had been in the beginning. (pp. 166-67)

Although Heller wanted to savor his gain and determine his next move in therapy, a protocol forbade his doing so.

Parham (1987) discussed the case of Longmore, a former faculty member at the University of Southern California Program in Disability and Society:

He was subjected to long hours of occupational therapy training for self-care skills although he had no intention of performing these time-consuming tasks independently at home. He planned to hire an attendant who would expedite the process, freeing him to use his time and energy to pursue more stimulating and productive activities. (p. 536)

Neither Heller’s nor Longmore’s treatments heeded Baum’s (1980) reminder that interventions notwithstanding, “we are nothing more than a bystander in the life of that individual until a relationship is formed” (p. 514).

A Health Care System Driven by Business, Efficiency, and Profit

Francis Peabody (1930), a physician, articulated the problem well when he argued that “hospitals, like other institutions, founded with the highest human ideals, are apt to deteriorate into dehumanized machines” (p. 33). Many narratives suggest that this dehumanization stems from a system of providing health care that builds on business, efficiency, and profit.

The business of health care. Any business that aims to offer individual service to large numbers of people may suffer from criticisms such as Sarton’s (1988):

A small incident in the hairdresser’s has given me something to try to understand . . . While Donna was securing my hair into curlers, an old lady who was waiting to be picked up came and stood beside us and talked cheerfully about herself and her daughters and Donna responded. It was through God’s own gift, was an animal being groomed. (p. 255)

The number of patients who seek treatment can compromise caring expressions in hospitals. As Savason (1985) wrote, “The clinician becomes a rationer of time, and that obviously sets drastic limits on the degree to which the ever-present client need for caring and compassion can be met” (p. 170). The result of that rationing is the feeling articulated by Peter Peabody during his visits to a busy clinic: “I just feel like they don’t give a damn . . . I feel like I’m always being ignored, they don’t care” (1986, p. 172). Additional complications associate with the business of hospitals, however, by virtue of their lifesaving function. Hodgins (1964) discussed the personal estrangement that occurs with the rapid interventions warranted by life-threatening illness.

Speaking as a patient, I think this point is important: that the stroke victim is most likely to encounter, as his first medical ministerant, a physician to whom he is a total stranger. Since speedy hospitalization is usually a first goal in stroke, treatment by strangers is likely to continue. (p. 839)

Peabody (1930) explained one consequence of the lifesaving business:

When a patient enters a hospital, the first thing that commonly happens is that he loses his personal identity. He is generally referred to, not as Henry Jones, but as “that case of mitral stenosis on the second bed on the left . . . it leads, more or less directly, to the patient being treated as a case of mitral stenosis, and not as a sick man.” (p. 34)

The problem is a matter of focus; the institutional eye sees the relevance of saving Henry’s life and so does not capture the wider clinical picture—that although “Henry happens to have heart disease, he is not disturbed so much by dyspnea as he is by anxiety for the future” (Peabody, 1930, p. 34).

The efficiency of the health care system. Murphy (1987) has spoken to the kind of ordering that occurs in institutions, renaming the hospital an island invaded by a rationalized system of schedules and shifts: “The hospital has all the features of a bureaucracy, and, like bureaucracies everywhere, it both breeds and feeds on impersonality” (p. 21).

The impersonality is well illustrated in Sarton’s (1987) account:

The scariest part of the hospitalization for me was not the surgery but the doctor rounds. On the mornings when these rituals were scheduled, the nurses and aides awakened us much earlier than usual. Meals and wash-ups were rushed . . . when they were to come, the surgeons, the residents, the interns . . . They entered our ward, about fifteen adults . . . Strange, long words were uttered, hairplates were opened and quickly closed. (p. 33)
Geboly (1990) recalled that only on the fourth day of her hospital stay did a nurse’s aide wash her hair, which was bloody and dirty from an automobile accident. The aide did so after her shift was over because the highly regulated day precluded this helping task. Sacks (1983) concluded that “the hospital, in short, is a singular mixture, where freedom and bondage, warmth and coldness, human and mechanical, life and death, are locked together in perpetual combat” (p. 24).

The battle sometimes seems insane, Murphy (1987) explained, because like most bureaucracies, the hospital has turned “capricious, arbitrary, and irresponsible as Wonderland’s Red Queen” (p. 44). One feels the capriciousness in Beissler’s (1989) experience with heartless caretakers:

In one hospital, the first hour of the nurses’ shift was spent in a detailed discussion of who would take coffee breaks when. Medications, patient needs, all other things paled in comparison. Sometimes people would literally leave you in midair in a lift to go on a coffee break, or leave you in some other awkward position, and just say, “It’s my break time.” (p. 35)

Brice (1987) recalled a nurse in the recovery room whom she asked for a blanket. The nurse, seeming much like the Red Queen, “harked I just brought you one; I’m not going to bring you another and disappeared” (p. 31). People are a hospital’s only possible conveyors of personal care; there can be no social life there if helpers are capricious and irresponsible. Sarton (1988) wearied of her treatment that was “bland at best, cold and inhuman at worst” (p. 103).

The profit of health care provision. Hodgins (1964) thought that helpers produce mostly problems with the profit-driven business of health care:

We have heard much sentimentation lamentation over the disappearance of the old “family physician” – dear, lovable old Dr. Peatmoss, who delivered all the babies, saw them through diphtheria, whooping cough and scarlet fever, sat at the deathbeds of the elderly, and never sent anyone a bill. This last lovable quality is, I suppose, why he disappeared. I felt no sense of personal loss at his passing because I never knew him. I should have liked to. The physicians in my life all had very efficient accounting systems – if not actual departments. (p. 840)

Longcope (1962), a physician, had argued even earlier that a business orientation causes the “quantification, mechanization and standardization” which are said to characterize this country” (p. 547). 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. Rabin (1982), a physician with amyotrophic lateral sclerosis, remembered that his physician gave him a pamphlet outlining the course of a disease that he already knew too well. He regretted that this physician gave him no suggestions about “how to muster the emotional strength to cope with a progressive degenerative disease” (p. 307).

Practitioners face a major quandary when their patients’ needs for time and compassion compete with the institution’s need to prosper. When high regard falls to those who treat the most patients or accumulate the most billable units of time, moments spent waiting, listening, or communicating are harder to justify. Sarason (1985) explained: “Whose agent I was became a pressing, daily, moral problem. I know what it is to have divided loyalties, to want to give up the fight, to rationalize away the internalized conflict” (pp. 170–171). And although few helpers buy the idea that patients are mere customers, many budget their caring actions. Patients experience the cuts as hurtful. Lear (1990) wrote of her husband’s regret that he had never attended to his patients’ experiences. He thought: “Damn it, doctors should know. They should care. Say how’re they treating you? How’s the food? Accommodations comfortable? Staff courteous? . . . . He himself would never even have thought to ask. Didn’t that make him negligent too? Ah. Bingo” (p. 43).

Occupational Therapists Within the System

According to Sacks (1983), occupational therapists are among those who struggle more successfully against the impersonality within the health care provision system: “There are, of course, gaps in this totalitarian structure, where real care and affection still maintain a foothold; many of the ‘lower’ staff nurses, aides, orderlies, physiotherapists, speech therapists, etc. give themselves unselfishly, and with love, to their patients” (p. 24). But occupational therapists speak openly about the frustrations of clinical practice; as Howard (1991) wrote, “occupational therapy does not exist in a vacuum” (p. 878). Growing numbers of patients are a concern. Departments must handle more patients with fewer staff members because “productivity and efficiency are becoming high-priority goals” (p. 878). Howard argued that technological approaches are thus “valued more than the holistic use of a variety of methods” (p. 880).

The climate in hospitals seems one of “cost containment” rather than caring (Howard, 1991, p. 878). Kari and Michels (1991) wrote of their regret that “daily life for those living within the institution can become compartmentalized and focused on receiving services to alleviate dysfunction” (p. 721). Trahey (1991) saw the combat to which Sacks (1983) referred as a “struggle to integrate quality care with a businesslike approach to fiscal soundness” (p. 397). Burke and Cassidy (1993) called it the “disparity between reimbursement-driven practice and the humanistic values of occupational therapy” (p. 173).

Boyle (1990) questioned one aspect of the dilemma:

Are occupational therapists today meeting the needs of the rehabilitation population and considering their social, political, and economic status? Or are we compartmentalizing our services on the basis of our own need for next, merely treatment plans that fit our expertise and the selective mission of our institution? (p. 941)
The enormity of the challenge pressed Grady (1992) to ask a more fundamental question: "Is there still enjoyment in occupational therapy, or have we become so-controlled with the realities of productivity, reimbursement, and modalities that we are failing to see the process as part of the outcome?" (p. 1063) A number of therapists have spoken to the powers essential for the struggle.

Knowledge is one:

All occupational therapists should have the knowledge, skills, and attitudes to position themselves to gain influence, power, and control of the systems in which they operate. To move upward in the power hierarchy, we must have knowledge (i.e., expertise), knowing (i.e., process skills), competencies, and credentials (Nielsen, 1991, p. 894).

But that competence, wrote Dickerson (1990), must be tempered by another concern: "Cure must also be exercised so that therapists never sacrifice quality of care for increased profits" (p. 137).

The quality of care central to occupational therapy has traditionally included the assumption that "if therapists are to create individually designed, personally meaningful treatment programs, then they must spend considerable time and energy getting to know each patient as a person" (Burke & Cassidy, 1991, p. 173). More and more, according to Burke and Cassidy, occupational therapists "must use a technical, protocol-driven approach to treatment" (p. 174). "Like physicians," they wrote, "we have had to amend our traditional allegiance to the patient due to increased fiscal restraint, which requires that we now consider the economic realities of the hospitals in which we work" (p. 174).

Conclusion

Caregivers such as Vanderwoude (1988) have paused after the course of their own illness to explain: "My illness was beneficial in helping me to be more reflective, in teaching me an element of patience, and in heightening my understanding of the person facing possible terminal illness." (p. 125). Sacks (1984) was similarly convinced: "I saw that one must be a patient, and a patient among patients, that one must enter both the solitude and the community of patienthood, to have any idea of what being a patient means" (p. 172). Although such an experience offers a profound form of knowing, first-person narratives can also inspire helpers to consider the manner in which they care.

Occupational therapists who choose how they will be among their patients do so within a context shaped by an intermingling of personal, professional, and societal beliefs. Occupational therapists have traditionally encouraged a practice based on competence and caring (Peloquin, 1990). Therapists who act as either technicians or authoritarian parents disappoint patients with their overvaluation of competence. Several societal beliefs can be seen to connect with such overly competent enactments:

an emphasis on the rational fixing of problems, an overreliance on method and protocol, and a health care system that thrives on business, efficiency, and profit.

A focus on fixing bodily parts and functional problems leads to a tendency to disregard a patient's understanding or feelings about illness. To a patient, the disregard feels technical rather than personal. A reliance on protocols that have success, authority, and reliability leads to a tendency to deny a patient's control, to dismiss a helper's intuition about what is right. To a patient, this preeminence of protocol feels impersonal and authoritarian. The routinization and rationalization of health care institutions lead to discourteous behaviors. The actions feel efficient but uncaring. Therapists who act as technicians or authoritarian parents reflect society's preference for the rational fixing of problems, the implementing of successful strategies, and the management of solvent businesses. And although each of these orientations is important and worthy of affirmation in any health care practice, overvaluation of any one of these can compromise the actions and words that mean care. Practice that values the person must build on both competence and caring.

Toward the end of his personal litany of complaints, Hodgins (1964) remembered the need that helpers also have for courage in the face of illness. He ended his address to the Academy of Physicians by suggesting that practitioners consider a picture of practice that might replenish their commitment: "Reclothe yourselves in humanity" (p. 842). It is hoped that occupational therapists will be among those who will hold fast to this image of personal caring as they practice competent care.

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References


