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Short Communication Open Access

Client Centered for Inclusion

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Currently within the field of communication disorders there is a struggle between institution-centered (medical model) approaches to clinical interventions and client-centered ones [1]. The purpose of this paper is to delineate the differences between these two approaches and the current American medical context which has favored the institution centered approach.

I began my clinical career as a diagnostic audiologist. I was taught in my training program to conduct exams by taking a case history, testing the client and then counselling. The counselling was always content based and involved an explanation of the audiogram and a recommendation for how the client should proceed. This was essentially the medical-model or institution-centered model of service delivery. In this model the professional is the expert and client is the passive recipient of the expertise. The emphasis in is on causality and cure, and the client's psycho-social issues are seldom addressed; in fact, as a graduate student I was instructed to refer the client to a mental health professional if emotions emerged in my interactions. Speech therapy had a similar professional-centered bent with a lesson plan devised and executed by the therapist. The advantages of this model are many:

- Meets client expectations of a professional as all-knowing.
- Provides a structure and control of the clinical interaction for the professional.
- It is easy to teach and relatively easy to learn for a beginning, insecure student with little experience to draw upon.
- It maximizes professional time and ease in scheduling.

The medical model has some negatives; it tends to minimize the psycho social aspects of clients and it lends itself to a mechanistic view of the clinical encounter; clinicians can easily become technicians and counsel by rote. After working several years as a clinical audiologist I developed set speeches explaining the audiogram and how hearing aids worked. I began to not "see" the client. Some of our earliest studies of clinical efficacy have shown that content based counselling at the time of diagnosis is ineffective; that clients retain little of the information provided. When emotions are high, as they usually are for a client, at the time of diagnosis, their ability to process what is being said is impaired and clients retain little of the information presented [2,3].

There is evidence now that there is growing dissatisfaction within the medical profession with Institution-centered practice. In a provocative op-ed piece in The New York Times, Robert Wachter, interim chair in the department of medicine at the University of California, noted how measurement in the fields of education and medicine have distorted the altruistic underpinnings of these professions [4]. He noted that; "Our business-like efforts to measure and improve quality are now blocking the altruism, indeed the love that motivates people to enter the helping profession.

The economic realities in health care are driving the medical model of service delivery which mandates more clients seen and less patient time spent. This puts emphasis on the economics of the profession and with it the need to produce billable hours and evidence based practice to justify the inclusion of communication disorders in service delivery. The danger is that the clinician can spend time counting numbers and forget about client needs and lose the altruistic rationale for entering a helping profession in the first place.

Ironically, the economic thrust for institution-centered interventions seems to be generating dissatisfaction with the actual clinical work and is leading to the growth of client-centered programs, which conform more to the idealism that propels people into the helping professions. I have recently read several articles in communication disorders literature questioning the use of the medical model and a spate of articles incorporating client-centered practices in clinical interactions and several more promoting family-centered practices [1,5-9]. I find this heartening and reflecting a trend in clinical practice; however, many of these programs are foreign based where there is a single payer system and therefore less need to generate profit.

In client-centered clinical interactions the professional is not seen as the 'expert" rather he or she enters a therapeutic alliance with the client to jointly arrive at the diagnosis or treatment plan. It demands that the professional listens to the client and pays attention to the emotional needs of the client, always promoting client ownership of decisions made; it is a collaborative model as opposed to an expert model. The professional trusts that clients have the wisdom to make the best decision for themselves when given information, time and emotional support [10].

This model extends into the diagnostic and therapeutic realms which should lead to better compliance and better carryover because the client is taking ownership in the therapeutic process. This should also lead to more professional satisfaction because it enables clinicians to work intimately with clients in promoting their personal growth by incorporating the psycho-social components in the clinical endeavor. Unfortunately, there is almost no research evidence to support this although logically it would seem to be more clinically effective for the long term than institution-centered models.

The negatives to the client-centered approach are:

- Does not conform to client expectations of professional as "expert" and may generate anger.
- Progress is often hard to define and measure.

- Difficult to teach and for students to learn because there is no apparent structure.
- Requires more time in the initial clinical encounter and may not be judged to be cost effective.

Becoming more client-centered is an evolutionary process both for the profession of communication disorders and for the clinician as it is born of experience and self-confidence. At its inception, speech pathology and audiology needed to begin with a medical model as it helped to establish professional credentials giving it a scientific base, and for the beginning clinician the necessary structure to learn therapeutic and diagnostic techniques. As a clinical profession matures and as a professional, becoming more confident, there is less need for the protective coating of the medical model and clinicians are ready to engage in more client-centered practices.

I think the field of communication disorders is currently on the cusp of making that evolutionary step; however, the economics of the current medical and educational landscape clearly favor institution-centered practice. It is here to stay and within the confines of the medical model clinicians must blend in ways to be client centered. Carl Rogers, the father of client-centered psychotherapy, was asked "What do you do when you only have 20 minutes?" His response was "20 minutes worth" [11].

The clinician still has control of the therapeutic encounter and within the restrictions of the medical model can approach clients mindfully and with compassion to their satisfaction by doing "twenty minutes worth" of client centered practice. We need also to provide students examples of client-centered practice in their training programs and hold this out as the gold standard of clinical interaction. Ultimately, the field and clinicians evolve into wisdom based practice which utilizes clinical knowledge tempered with life experience and compassion and always involves a profound awareness of the clinical context.

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