Two major forces are changing the shape of health care for the frail elderly with disabling conditions: increasing emphasis on quality of life and growing reliance on an interprofessional team-based approach to care. This article outlines a conceptual framework for organizing discussions of quality of life for elderly persons with disabilities, reviews relevant empirical research, and develops a framework for understanding the different dimensions and interpretations of this concept — particularly as it is used in communication among health care providers, and between them and their elderly patients and families. New models of health care to enhance the focus on life quality and collaborative team practice are summarized. Proposed is the development of an “empowering and reflective ethic” to achieve more effective communication about quality of life in geriatric clinical practice.

Key Words: Ethics, Clinical practice, Communication, Health care teams

Quality of Life, Values, and Teamwork in Geriatric Care: Do We Communicate What We Mean?¹

Phillip G. Clark, ScD²

The expression “adding life to years rather than years to life” captures the changing direction in the care of the frail elderly over the last decade. From a past emphasizing of the “heroic” model of medicine extending life at any cost is emerging a more “humanistic” model of care, focusing on individual quality of life. As acute illness has increasingly given way to chronic disease as the major health challenge facing Western societies — mirrored in greater numbers of the elderly at risk for chronic illness and its associated disabling conditions — a gradual shift from curing to caring is occurring within our health care system. This transformation is still in process, however, creating conflicts and communication problems between health care providers, as well as between these professionals and the frail elderly and their families.

Solving these problems hinges on the continued theoretical development and practical application of new concepts to guide geriatric care, such as quality of life. However, this concept means different things to different people, whether providers or consumers of care. In assessing these differences, it is important that we carefully examine our thought and language, and ask the question: “Do we understand and communicate what we really mean?” in clinical practice and decision-making settings involving frail older persons — whether institutionalized or living in the community. In particular, individual and cultural values play an important role in defining and operationalizing the concept of quality of life. For example, families may differ considerably in their definition of the burden of care created by a frail, impaired member and their resultant assessment of the quality of that life (Kayser-Jones, 1986). Similarly, a poor quality of life for one person may be a rich life for another: What we might consider to be a life full of sickness, frailty, and dependence might provide another person with new insights into the existential nature of human life and its continual conditionality and precariousness (Gadow, 1983). Importantly, over-emphasis on individual independence in constructing a definition of quality of life may neglect the values of community, collectivism, and interdependence that are equally important in human existence (Clark, 1991a). Clearly, the concept of quality of life is at once crucial and confusing, important and intangible, clinically central and conceptually elusive.

¹Portions of this article were presented in a symposium on Humanistic Perspectives on Quality of Life: Biography, Literature, and Clinical Practice and Communication, at the 46th Annual Scientific Meeting of The Gerontological Society of America, New Orleans, November 19–23, 1993. The author would like to thank two anonymous reviewers for their helpful comments on an earlier draft.

²Address correspondence to Phillip G. Clark, ScD, Professor and Acting Director, Program in Gerontology, The University of Rhode Island, Kingston, RI 02881.
In order to respond to this challenge of relating quality of life to communication patterns in geriatric care, the purpose of this discussion is multifaceted. First, it outlines a framework for understanding the different dimensions of the concept of quality of life for elderly persons with functional disabilities — particularly as it is used in communication among health care providers, and between them and their frail elderly patients and families. By examining the differing assumptions and values underlying this concept, we may achieve a better understanding of differences in its use and thereby improve communication about it in the future. Second, this article examines and summarizes empirical research on: (1) professional communication involving elderly patients and their families, with respect to the barriers to effective dialogue around the concept of life quality; and (2) interprofessional communication patterns, particularly those involving physicians, nurses, and social workers. This discussion provides concrete examples of how quality of life notions can be interpreted very differently by different persons. Third, a conceptual framework — based on emerging medical, nursing, and social work models — is proposed for more effectively involving the concerns, goals, and values of the frail elderly individual in the dialogue with health care providers over issues of quality of life. Finally, the conclusion explores methods for achieving more effective overall communication to reveal the essential dimensions of quality of life and how it may be operationalized in clinical practice, a process I will term “developing an empowering and reflective ethic.”

Thinking About Quality of Life for the Frail Elderly

Discussions of such concepts as quality of life are fraught with major conceptual and practical challenges. Not the least of these relates to clarifying its different foundations and dimensions. The concept of life quality is seen both as deeply personal and subjective, and as a kind of general intuitive yardstick with which to make clinical decisions about the wisdom of pursuing various types of treatments for very frail older persons. The purpose of this section is not to provide an exhaustive examination of all the facets of this concept, but rather to explore it in sufficient detail to highlight some major developments in the fields of gerontology and geriatrics that may help us to think more clearly about what it really means in the lives of older persons with disabling conditions. The three themes which I wish particularly to discuss are: (1) the growing attraction of the level of personal functional ability as a proxy for the more slippery concept of life quality; (2) the relationship between autonomy and quality of life in the gerontological literature; and (3) lessons to be learned about quality of life from the independent living movement.

Accompanying changes in the focus on health care outcomes for the elderly are new measurement methodologies that seem to be intuitively related to quality of life. For example, the long-used indicator of life expectancy has recently been replaced by Katz et al.’s (1983) and Katz, Greer, Beck, Branch, and Spector’s (1985) concept of functional life expectancy, defined as simple survival in the former but by independence of personal function in the latter. Growth of interest in individual functional ability is apparent in the increasing emphasis on functional assessment of elderly persons, advocated by such official groups as the American College of Physicians (Almy, 1988) and the Society of General Internal Medicine (Rubenstein et al., 1989). Assessment methodologies are typically multidimensional, reflecting the multifaceted nature of the health problems of older persons, and they incorporate biological, psychological, and social aspects of an individual’s life — further reinforcing their appeal. Moreover, this expansion of clinical concerns beyond the realm of a narrow medical model has helped to support the growth of interprofessional health care teams in assessing and managing the health problems of the elderly with disabilities, based on the simple recognition that not any one health discipline “owns” an in-depth understanding of them (Tsuchida, 1990; Zeiss & Steffen, in press).

There are major potentials and pitfalls in equating functional independence with quality of life. This is seen clearly in the growing literature on autonomy and aging. For example, research has linked personal control or autonomy to the concept of successful aging in particular (Rowe & Kahn, 1987) and more generally to positive health outcomes (e.g., Langer & Rodin, 1976; Rodin, 1986; Rodin & Langer, 1977). Others have seen quality of life and autonomy critically linked to health care decision making for older persons (Clark, 1987; 1988) and to their empowerment in the health care system (Clark, 1989). Indeed, entire issues of major gerontological journals have been devoted to the central importance of preserving autonomy in frail, at-risk elderly populations — for example, supplements to The Gerontologist in 1988 and to Generations in 1990.

Two important caveats to this heavy reliance of quality of life language on measures related to functional independence and autonomy must be mentioned. First, over-reliance on simple individual autonomy ignores the critical contributions made to life by a sense of community. Certainly the important contribution of social supports in maintaining independence is a major theme in gerontology that nicely captures the paradox in our thinking about autonomy. Even in long-term care settings in which autonomy has traditionally been emphasized the most, other voices are being raised that question its perceived domination. For example, although Kane and Caplan (1990) underscore the importance of autonomy for the nursing home resident, they also explore the situational complexities of over-emphasis on this single concept in an institutional context. Similarly, Agich (1990) suggests the need to consider the complex interrelationship between dependence and independence in long-term care. Collopy, Boyle, and Jennings (1991) explore the limitations that traditional individualistic conceptions of autonomy impose on the nursing home setting, and they call for
the development of the notion of “autonomy within community” as an appropriate expression of this insight. In the community long-term care setting as well, authors such as Collopy, Dubler, and Zucker (1990) suggest that the simplistic dichotomy between independence and dependence no longer accurately describes the complexities facing elderly, frail individuals, and their families in the struggle to provide care and support to loved ones.

A second caveat is to be found in the expanding literature on disability and aging. Minkler (1990), for example, warns that the growing reliance on the concept of “successful aging” may reinforce the prejudice against elders with disabilities — the “elderly mystique” explored earlier by Cohen (1988). Calling for the development of a unified, dialectical approach to aging instead of the bipolar, “successful” versus “unsuccessful” dichotomy, she draws on the independent living movement for inspiration and guidance concerning the abilities and capabilities of the disabled. Older persons themselves may fall victim to the elderly mystique stereotype, assuming that the onset of disability associated with chronic health problems marks the beginning of inevitable decline and the end of control over their lives — their perceived “failure” in growing older. Even worse, practitioners, program planners, and policy makers may unwittingly reinforce this message by fashioning programs based on the success/failure dichotomy (Cohen, 1992).

The growing conjunction between the aging and the disabilities fields (e.g., Ansello, 1992; Ansello & Eustis, 1992; Ansello & Rose, 1989) provides an important insight into the interrelationships among autonomy, disability, and human services that has implications for our thinking about quality of life. As Cohen (1992) observes for the independent living movement, autonomy relates to the achievement of individual consumer goals; services are seen less as compensating for physical and psychological deficits than as enhancing or limiting independence. Importantly, services are evaluated on the basis of whether they are controlled by the consumer or by the agency; they should be directed at goals that enhance the meaning of life by encouraging involvement and engagement — not simply assuring survival and postponing institutionalization. This important distinction is captured conceptually by Collopy’s (1988) exploration of the polarity in decisional versus executional autonomy: Decisional autonomy consists in the freedom to make decisions without external coercion, whereas executional autonomy is the ability to carry out and implement these personal choices. Giving individuals with disabilities power to control their use of services to act on their own goals in life becomes an essential element linked to their perceived control — not whether or not they have a disability. Moreover, the control of services needed to operationalize choice must rest with the consumer, not the agency. This way of framing autonomy and the use of services is very different from that traditionally prevailing in the aging service network, and it can give us an important insight into the social construction of aging and disability to clarify our thinking about quality of life for the frail elderly.

Communication About the Meaning of Quality of Life Among Providers and Consumers

Issues relating to assumptions, concepts, and values surrounding the meaning of quality of life for the frail elderly are not simply “academic” — they have major implications for how providers and consumers communicate with each other in making health care decisions, and for how professionals communicate with each other in collaborative or interprofessional contexts.

Dimensions of Meaning of Health and Life Quality for Providers and Consumers

As discussed earlier, service providers may dichotomize aging into positive and negative (healthy and disabled) categories, and develop and offer services for the frail elderly based on a deficit model. Under these conditions, services may be “packaged” by providers in response to their definition of what is the elderly individual’s particular disability. The communication problem here is that a major conceptual gap exists between professionals and laypersons with regard to their construction of the meaning of health and health-related problems. Providers and consumers approach health issues from different perspectives — with the former reflecting the professional and organizational concepts and patterns of practice in which they have been trained, and the latter embodying different influences from their personal experiences, familial contexts, and cultural backgrounds (Dill, 1993). Providers and consumers speak different languages, though they may use the same words.

Moreover, because of differentials in power between the professional and the patient, the professional’s definition of need, or the “problem” to be “solved,” usually takes precedence over that of the client. The person who controls the definition of the problem simultaneously defines the range of options available to solve it (Clark, 1993) — an insight having both clinical (Dill, 1993) and public policy relevance (Aronson, 1992; 1993). In other words, recipients of clinical care and public policies must have genuine input into the basic construction of need and the concepts used to describe it, or else consumers will be prevented from effective dialogue and discussion regarding the important outcomes of the needs assessment process. Unfortunately, frail older persons may not even be aware that their needs are being defined by others, and they may have to be empowered to break out of this pattern — as the independent living movement has accomplished for younger persons with disabilities.

This definitional difference is especially apparent in the perceptions of health by the elderly. For example, research (Mangione et al., 1993) has shown that the elderly have a greater gap between their objectively and subjectively assessed health status than
younger age groups. In particular, they report similar overall health perceptions to younger persons even when they are “objectively” assessed as having poorer role function, lower energy levels, and less physical function. This difference between subjective and objective measures of health status in the elderly has been recognized for some time by researchers who were puzzled by high self-reported global health assessments and low objectively defined health scores.

Even taxonomies of quality of life that are broadly defined to include the comprehensive categories of functioning (social, physical, emotional, and intellectual) and perceptions (life satisfaction and health status) may not necessarily guarantee that professionals will understand quality of life of the elderly with disabilities, because they were not derived with input from patient populations themselves (e.g., Pearlman & Uhmann, 1988). This lack illustrates the crucial importance of involving client populations in the development of frameworks defining need.

Indeed, research into the perceptions of quality of life among elderly persons with chronic diseases found a disparity between how this concept was interpreted by physicians and their patients. Generally, elderly patients considered their quality of life to be “good enough” if they had no major complaints, regardless of the degree of severity of their illness. In contrast, physicians rated their patients’ quality of life as significantly worse. In this same research, in their responses to open-ended questions patients emphasized medical care, health-related problems, and interpersonal relationships (involving family and friends) as factors affecting quality of life (Pearlman & Uhmann, 1988). Importantly, subsequent research by these same authors (Uhmann & Pearlman, 1991) has shown that physicians’ estimations of quality of patient life are significantly associated with their attitudes toward life-sustaining treatment for their patients. This demonstrates the important clinical decision-making implications of differences in interpretations of quality of life, given that patients’ perceived quality of life was not found to be associated with their preferences for life-sustaining treatments.

A similar disparity between professionals on the one hand and frail, elderly patients and their families on the other is echoed in the research to map values and priorities on the type and quality of communication between health professionals and their patients and families, particularly with regard to what different aspects of quality of life each selectively emphasizes. How can both sides in this dialogue be assured that each party understands the other, that “what they are saying” is truly understood by the other in an ongoing attempt to make the difficult decisions embedded in the constantly shifting settings of long-term care, where quality of life considerations figure prominently in how decisions are made? More importantly, how can professionals develop the kind of inner moral reflectivity and sensitivity needed to detect and understand these important value differences?

Some commentators suggest that the development of a “communicative ethic” may overcome these problems. For example, empirical research (Miller, Coe, & Hyers, 1992) documents that some physicians take into account the concept of “patient wishes” as a central, organizing theme in initially attempting to reach consensus among patients and their families on withdrawing or withholding care for critically ill patients. Physicians were judged in most cases to provide direct and unambiguous introductions to the concept of limiting treatment and to encourage a participatory style of decision making to balance the competing goals of extending life, providing high quality life, fostering patient autonomy, and maximizing social justice (i.e., balancing competing obligations). Unfortunately and importantly, however, this research also showed that by the end of the discussion, many physicians had shifted to a shaded presentation of outcomes reflective of their own biases.

The philosophical basis for open communication in the long-term care decision-making context has been developed by Moody (1988) in his concept of the “communicative ethic” emphasizing the “three Cs” of “communication, clarification, and consensus-building” in negotiating the shifting shoals of client autonomy and professional paternalism in long-term care decision making for the frail elderly. Although recognizing its imperfections, Moody suggests that such a procedural ethic based on communication is preferable to a static, principled approach...
that is frequently unattainable in professional practice. Moreover, when dealing with particularly thorny quality of life considerations, it should be obvious by now that the various professional parties in this discussion need to examine the concepts, assumptions, and values underlying their various approaches to defining the clinical problem and seeking its solution. Hence, we must now turn to issues relating to communication among different health care professionals.

Communication Among Professionals: Do We Say What We Mean on the Interprofessional Team?

Due to the multifaceted nature of the chronic health problems of the frail elderly, the need for teams of professionals from different disciplines to work together in creating and coordinating necessary care has become widely recognized (e.g., Clark, Spence, & Sheehan, 1987; Tsukuda, 1990; Zeiss & Steffen, in press). However, simply assembling professionals into a group falls far short of developing an effective team in which patterns of communication are at the level necessary for true interdisciplinary functioning (Clark, Spence, & Sheehan, 1986). This fact is evident in a widely quoted definition of the interdisciplinary team (Luszki, 1958; cited in Given & Simmons, 1977, p. 16):

The interdisciplinary team is a group of persons who are trained in the use of different tools and concepts, among whom there is an organized division of labor around a common problem with each member using his own tools, with continuous intercommunication and re-examination of postulates in terms of the limitations provided by the work of the other members and often with group responsibility for the final product.

The development of a truly interdisciplinary team requires recognition of the importance of both knowledge- and value-related dimensions of professional practice (Clark, 1991b). Values, in particular, are a major source of conflicting and competing communication patterns among health professionals, who are educated and trained in very different modes and methods of practice with regard to their relationships with each other, as well as with the client or patient (Clark, 1994). The concept of quality of life is fraught with divergent interpretations precisely because of these differences in how health care professionals are socialized into differing systems of care.

For example, Qualls & Czirr (1988) suggest that professionals may differ in their logic of geriatric clinical assessment; that is, how to define the problem. This difference may be characterized by two different styles of practice, one emphasizing “ruling out problems” by systematically eliminating possibilities until only one problem and a corresponding solution are discovered. In contrast, the other approach of “ruling in problems” relies on expanding the range of professional view to encompass an increasingly long list of potential factors. For example, physicians are trained in diagnostic techniques that narrow down the range of options, relying heavily on “objective” data such as laboratory tests in the process. Social workers, on the other hand, are taught to go beyond the narrow presenting problem to encompass larger psychosocial issues, such as income, family relationships, and environment. In this process, they tend to rely on “subjective” data collected by interviews that are heavily interpreted by clinical judgment and experience. Nurses, depending on their background and training, may fall somewhere between these two extremes. Such differences in delimiting the domain of inquiry in clinical practice have major implications for communication over such conceptually slippery concepts as quality of life. For example, empirical research in nursing homes has found that physicians and nursing assistants (whom we may consider to be aligned generally with nursing practice models) differ considerably on their feelings about the basis for life-extending treatment and the meaning of care (Kayser-Jones, 1986):

To the nursing assistants, caring is a more important factor than mental and physical status of the patient. “We are here to take care of these patients,” they repeatedly stressed. Physicians, they believe, are oriented toward curing illness, and when a cure cannot be achieved their interest in caring for the patient may tend to decline. A 63-year-old physician confirmed the nursing staff’s observation: “The nursing untreatable the condition, the more disinterested there is on the part of younger physicians in treating the patient.” . . . One doctor confirmed that in some cases he would prefer to withhold treatment, but, because the nurses were so pro-life, he would be in trouble if he did not treat the patient (pp. 1282–1283).

Additional findings from this research revealed that differing interpretations of the concept of quality of life underlay these differences in approaches to care. For most physicians, quality of life was related to mental status or freedom from mental impairment; by contrast, quality of life for nurses was more relative. Physical strength, even in the presence of mental impairment, was considered a key determinant of quality. This contrast can be seen in typical comments about quality of life. One doctor said: “Quality of life is being mentally unimpaired, being continent of urine and feces, being able to talk, and knowing who you are.” When nursing assistants were asked to define quality of life, they responded: “Being able to see and hear, good health, having friends, and having someone to love you” (Kayser-Jones, 1986, p. 1284).

These differences in defining quality of life may be understood within the larger framework of disparities in the perception of ethical problems by physicians and nurses. Divergence between these two professions with regard to the recognition of moral dilemmas in practice suggests that such differences are crucial to understanding why communication about such value-laden concepts as “quality of life” can be so difficult. For example, Gramelspacher, Howell, and Young (1986) found that physicians and nurses differed significantly within each group with regard to how often they perceived ethical dilemmas, and that nurses were much more often to report conflicts with
physicians to recognize disagreements with nurses. Subsequent research by Walker, Miles, Stocking, and Siegler (1991) also found significant differences between nurses and physicians with regard to the ethical problems they identified. For example, three-quarters of the problems centering on a patient’s quality of life were described by physicians rather than nurses. The authors explained the disagreement over ethics problems as a function of professional orientation and socialization, with nurses increasingly oriented toward patient-centered issues—such as patient preferences, family issues, pain control, implementing treatments, and discharge planning. By contrast, physicians were directed more toward problems embodying increased concern about the cost of care and the proper use of medical resources—such as quality of life, economic factors, and inappropriate admissions. Importantly, physicians’ concerns about quality of life were interpreted as consistent with previous research (summarized earlier) linking life quality considerations to decisions to withhold therapy, and to the tendency of physicians to rate the life quality of chronically ill elderly more negatively than do their patients.

In addition to medicine and nursing, social work affords us another perspective on the differences underlying the health professions regarding life quality interpretations involving the frail elderly. Social work has traditionally represented the broader psychosocial perspective on quality of life concerns in health and illness (e.g., Sharp, 1993). This view entails the involvement of several relevant dimensions, including: (1) an assessment of the social environment (including family, social support, economic and cultural factors, and the physical setting); (2) the right of the individual to make his or her own decisions (autonomy); (3) the identification and mobilization of resources in the family and the community; and (4) mediation among the major professional and institutional “players” in defining and solving the elderly individual’s “problem” (Jones, Meredith, Wadas, Watt, & Weisz, 1991). This philosophical orientation ensures that the individual’s perspective on, and definition of, quality of life will be incorporated into the ongoing discussion among other health professionals, the patient or client, and the social worker—an important principle discussed earlier. However, the very skills that social workers employ to make certain that individuals have a voice in decision making about their own lives may not serve them well in working with other health professionals. Indeed, some observers (such as Kane, 1975) suggest that social workers’ ability to communicate on the interprofessional team may be impaired by their socialization and professional orientation. Given the central importance of including in clinical decision-making processes individuals’ values and personal perspectives on what constitutes quality of life for them (Cassel, 1992), it seems imperative that this essential orientation not be lost in the dialogue among the different professions represented on the interdisciplinary team. New models of health care may be required to address this communication-related need.

New Models for Care and Communication

It is significant that along with the dual emphasis on the concepts of quality of life and the interdisciplnary team in clinical geriatric practice have emerged new theoretical frameworks to integrate into the care model the values of the individual client or patient that shape his or her definition of quality of life. These new approaches promise to break down the barriers separating patients from care providers, and the providers from each other; and they are suggestive of ways to change forever how health professionals conceptualize their roles and goals in caring for the frail elderly with disabling conditions. Importantly, the principle of empowerment of the consumer, client, or patient in defining quality of life is a central organizing theme of these approaches.

Beyond Biomedical Nursing

Theories of nursing reflect different emphases and assumptions, with some clearly tied to the prevailing biomedical model which tends to be “problem-based,” with an emphasis on functional abilities, problems, deficits, and special needs determined by assessment methodologies and evaluations by “experts.” Some observers (e.g., Mitchell, 1992) have noted that the compartmentalization of the individual into such categories lends itself well to the interprofessional team, with each specialist “owning” a particular part of the patient or client. In contrast to this model, however, is a more holistic one, such as that developed by Parse (1987; 1992), which emphasizes the unity of the individual—who is not known simply as the sum of various parts. Rooted in a humanistic ethic, this theoretical perspective emphasizes quality of life as perceived by the individual and his or her family. According to Mitchell (1992), “... health is not defined according to the biological, psychological, and social norms established by experts. Rather, health is a process of living what is important in daily life according to each individual’s value priorities, meanings, hopes, and dreams” (p. 104).

The emphasis on the lived experience and personal history of the elderly individual, embodying his or her own values and life goals, becomes the centerpiece of this model of caring; and different professionals on the interdisciplinary team are challenged to recognize that their caring must be directed to the concerns and goals of this person—not their own agendas, needs, and problem definitions. In particular, the old modes of thought and practice of health care disciplines, founded on problem-based methodologies of assessment and care plan development controlled by the professional, must give way to a new mode of practice driven by an ethic of communication about the goals and concerns of the individual. In summary:

The values of traditional nursing direct nurses to focus on assessment, prediction, and control of prob-
developed a new conceptual framework, “goal-oriented health care,” which embodies some of the same principles already discussed for nursing. Suggesting that the old model of problem-based care — founded on a biomedical model emphasizing the detection of problems, their correction, and the return of individual functioning to “normal limits” — is no longer suitable for geriatric practice, observers such as Mold, Blake, and Becker (1991) have offered a new vision of what medical care for the frail elderly should be. This model represents a revolutionary way to reconceptualize both health and health care. In brief, the old problem-based model is based on the following premises (Mold, 1995):

- There exists an ideal “health” state that each person should achieve and maintain. Any significant deviation from this state represents a problem, disease, or disorder.
- Each problem has one or more identifiable causes, whose correction will resolve the problem and restore health.
- Health professionals, because of their scientific understanding, are the best judges of the causes and appropriate treatments of problems.
- Clients/patients are expected to concur with health professionals’ assessments and comply with their recommendations.
- The success of health interventions is measured by the degree to which individual problems have been identified and appropriate techniques/technologies applied to solve them.

Although there are still relevant applications of the problem-based model, such as in treating an elderly person with an acute medical condition, it loses currency when dealing with the chronic, disabling conditions found in many elderly. Importantly, the issue is not only how the problem is described, but also who controls how the problem is defined and subsequently treated.

In contrast, the goal-oriented model embodies fundamentally different assumptions:

- Health must ultimately be defined by each individual, and it may be different for different persons and for the same person at different times.
- An individual’s health goals can best be determined through a dialogue involving the individual and his or her health care provider(s), each using the special information they bring to the caring relationship.
- The development of health goals requires assessing the individual’s strengths and resources, interests and needs, and personal values — in addition to determining obstacles and challenges.
- Final decisions about health goal priorities, and the amount of effort expended in their achievement, must reside with the individual. Health professionals must decide whether their involvement will be beneficial and how they can participate.
- Success for both the individual and the health professionals is measured by the extent to which the individual’s health goals are achieved.

Thus, in the goal-oriented framework, health is defined not as an outcome, but as a process, incorporating the following dimensions: physical maturation and differentiation, self-actualization, development of adaptability and coping skills, and the acquisition of wisdom — all potential aspects of quality of life considerations. In this process, health care professionals must enter into a dialogue with the elderly individual, each expressing the unique contributions of knowledge and skills brought to this relationship. It is through this collaborative process that a broader array of health professionals is brought into the personal health goal attainment of the individual than is generally the case with the problem-based model. With a wider definition of health, the degree of contribution and participation of disciplines beyond the traditional emphasis on medicine is now possible. Importantly, the relative contribution, role, and power of each discipline may vary with the unique goals of the older person with a disability.

In short, a goal-oriented model of health care recasts the traditional relationship between care provider and frail elderly recipient into a collaborative process, in which the values of the individual — as embodied in his or her personal and life goals — take precedence over the traditional control of professionals over the assessment of needs and development of solutions to problems. In this model, professionals will have to learn to listen more carefully not only to the individual, but also to each other. Such a model sets forth a new challenge for communication at all levels in the pursuit of health, in which the understanding of both information and values takes on a new urgency and importance.

Social Work: Empowerment With a History

The field of social work represents a third perspective on the development of innovative models of care incorporating new images of communication and power among providers and consumers of services. In addition to representing the major influence of psychosocial factors in defining health and assessing the origin of health “problems,” social workers have traditionally emphasized the rights of their clients to self-determination and acted in such a way as to help them recognize or develop their own skills to help themselves (Kane, 1975), principles that are increasingly relevant to the frail elderly who are at risk of losing control over their lives and the health care decisions affecting them. More recently, a renewed theme in social work has underscored the central importance of client self-determination and empowerment in social work practice (Tower, 1994). Drawing on the concepts represented by the independent...
living movement within the field of developmental disabilities, this trend embodies the shift from professionally determined problem definitions and solutions to consumer-defined needs and personal processes of discovering or creating ways of meeting them (Dejong, 1984). Thus, social work practice with the elderly is being increasingly influenced by empowerment strategies for persons with disabilities in general.

In this transition, the leadership of the geriatric team shifts from one of professional dominance to one of consumer control and power. Tower (1994) calls upon practitioners and instructors in social work to develop the basic knowledge and skills necessary to model empowering behaviors to clients and students alike. As Cohen (1988) has counseled gerontologists, we need to adopt a more robust ideological stance to embody new conceptual principles in the design and delivery of services, and he too draws on the inspiration of the independent living movement:

Traditional professional views see the consumer as the problem, focusing on the disability and skills deficits. From the independent living movement point of view, the problem is not in skill deficits due to disability, but rather in the dependence that is shaped by traditional service models and a society shaped by the needs, skills, capabilities, and demands of the dominant reference group (p. 26).

Thus, a shift away from professionally defined needs and toward individually determined goals in social work is dependent upon the empowerment of the frail, elderly health care consumer. Only by changing the underlying conceptualization of need, reflected in the socialization process of professional training, can new models and definitions of services be created.

Conclusion: Toward an Empowering and Reflective Ethic

If our vision of more effective collaboration among members of the health care team and the frail elderly individual over issues of quality of life is to be realized through new conceptual frameworks for clinical practice and communication, we need an innovative set of guiding principles to achieve this goal. Schön's (1987) concept of the "reflective practitioner" is, I believe, a good candidate for this purpose. For Schön, the true professional embodies competency in both the science and the art of practice; he or she is technically knowledgeable and capable — but, more importantly, is able to grapple with those "gray areas" of professional practice where value conflicts, uncertainty, and uniqueness conspire to undercut the "rationality and objectivity" of scientific practice. This area constitutes the domain of the artistry of professional practice, of which the formation of professional judgment is the hallmark. Judgment involves the thought processes involved in selecting and using information, developing intuition, and forming the reflective thinking that we associate with a high degree of professional development.

As I have argued elsewhere (Clark, 1994), collaborative interprofessional teamwork is a powerful method for training the reflective practitioner, because team participants are forced to recognize both the great power and the severe limitations of their own particular ways of generating and using information. In this sense, as Petrie (1976) has suggested, participants must acquire a basic understanding of the cognitive maps of other disciplines on the team, as well as that of the individual client or patient. By the term "cognitive map" is meant (a) the conceptual frameworks; (b) modes of inquiry and understanding; (c) problem definitions; (d) and observational, representational, and explanatory methods of other disciplines.

Not only must professionals gain insights into how knowledge is generated, used, and transmitted in professional practice, but — as Schön suggests — they must be able to understand equally well the value maps of other professions. These include an understanding of the basic normative assumptions, modes of ethical analysis or moral reasoning, and how value conflicts are resolved in different disciplines. The task of ascertaining the value maps of different professionals and the individual served by the team is the analogue to that of "public ethics," a term coined by Jonsen and Butler (1975) to describe the process of revealing and examining the principal values underlying and guiding the public policy process. In particular, public ethics examines the assumptions in the development of policy "problems" and assists in evaluating the range of alternative "solutions" to them. By extrapolation, the clinical value-mapping process must reveal how and why elderly individuals with disabilities choose different courses of action to address specific issues of concern to them about the quality of their lives. It helps to uncover the values implicit in our everyday lives and decisions, as well as those having professional relevance.

Most importantly, professionals must be open to the empowerment of the elderly individual with disabilities, the recognition that it is he or she who must define the appropriate means and ends of care. Restructuring health care around the unique individual and his or her experience with illness or frailty represents a new countertheme to medical control in traditional clinical practice (Reiser, 1993). A fundamental cornerstone of this emergent perspective is a concentration on the relationship between the consumer and the provider of care, emphasizing an understanding of the basic values and meanings attached by individuals to the health care encounter and its relation to their overall lives and life goals (Delbanco, 1992; Matthews, Suchman, & Branch, 1993). Attention to the nature of communication between care provider and recipient depends on the joint recognition of the need for dialogue, interdependence, and empowerment on both sides (Clark, 1989). Empowerment must include the kinds of reflective processes that underlie an understanding of whose interpretation of facts and whose selection of personal and professional values drives the pro-
cesses of defining and solving problems. This may mean the unmasking of professional constructions of “need” and their replacement with consumer-developed and inspired visions of what is really important in life. Mutual respect must emerge as the hallmark of this process if it is to be successful in achieving open communication and understanding.

In summary, providers and consumers alike must acquire an “empowering and reflective ethic.” This ethic should be an integral part of the artistry of professional practice—incorporating insights into both the knowledge base of professional practice and the normative dimensions of establishing important goals and how to achieve them. It should also be the foundation of what it means to be an empowered consumer. In this process, the term “quality of life” becomes a metaphor that incorporates these two dimensions into geriatric practice, because of necessity it spans both factual and moral aspects of care as perceived by provider and recipient. It is not accidental, I think, that this concept has emerged as important from the vision of a new, more collaborative model of professional practice, in which health and health care are increasingly visualized as a process of mutual exploration and discovery. In addition, we are guided in this conceptual transition by an understanding of empowerment and quality of life informed by both gerontology and the field of developmental disabilities. By meeting the challenges of communication about such important concepts we can gain fresh insights into the development of new ways of thinking and acting as health care professionals, individuals, and family members as we grapple together over what we mean when we say “quality of life” for the frail elderly.

References


410 The Gerontologist


Received May 9, 1994

Accepted December 21, 1994